FILED

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CASE NO.

IN THE SUPREME COURT OF THE UNITED STATES

October Term, 1995

COOPER TIRE & RUBBER COMPANY,

Petitioner

v.

ST. PAUL FIRE AND MARINE INSURANCE COMPANY, RICHARD C. PILLSBURY, M.D., and ROBERT MAZA

Respondents

Petition for Writ of Certiorari to the United States Court of Appeals for the Eighth Circuit

APPENDIX TO PETITION FOR WRIT OF CERTIORARI

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July 21, 1995

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UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

No. 94-2183

Cooper Tire & Rubber Company,	*	
Plaintiff-Appellee,	*	
v.	*	
St. Paul Fire and Marine Insurance Company,	*	Appeals from the United States District Court for the Western District of Arkansas.
Defendant-Appellant,	*	
Robert Maza,	*	
Defendant	*	
Richard C. Pillsbury, M.D.,	*	
Defendant-Appellant.	*	

No. 94-2209

Cooper Tire & Rubber Company,	*
Plaintiff-Appellee,	*
v.	*
St. Paul Fire and Marine Insurance Company,	*
Defendant	*
Robert Maza,	*
Defendant-Appellant,	*
Richard C. Pillsbury, M.D.,	*
Defendant.	*

No. 94-2240

Cooper Tire & Rubber Company,	*
Plaintiff-Appellee,	*
v.	*
St. Paul Fire and Marine Insurance Company; Robert Maza; Richard C. Pillsbury, M.D.,	*
Defendants-Appellees.	*

Submitted: December 12, 1994

Filed: February 27, 1995

Before MAGILL and BEAM, Circuit Judges, and PIERSOL, District Judge.

BEAM, Circuit Judge.

St. Paul Fire and Marine Insurance Company (St. Paul), Richard C. Pillsbury, M.D., and Robert Maza appeal an adverse judgment of the district court. After a bench trial, the district court found that Maza breached his contractual obligations to the ERISA plan of Cooper Tire & Rubber Company (Cooper Tire) by settling his medical malpractice claims against Dr. Pillsbury. The district court further found that Dr. Pillsbury and St. Paul (Pillsbury's malpractice insurer) tortiously interfered with the contract between Maza and Cooper Tire by settling with Maza. Because we find that Maza took no actions contrary to the terms of the ERISA plan, we reverse.

THE HONORABLE LAWRENCE L. PIERSOL, United States District Judge for the District of South Dakota, sitting by designation.

I. BACKGROUND

Cooper Tire maintains a self-funded and self-administered employee welfare benefit plan (the Plan) which is subject to the Employee Retirement Income Security Act (ERISA), 29 U.S.C. §§ 1001-1461. As an employee of Cooper Tire, Robert Maza received health insurance coverage through the Plan for himself and his wife. In 1988, Maza's wife became seriously ill and died. As a result of her illness, the Mazas incurred covered medical expenses totaling $298,118.07. Cooper Tire reimbursed the Mazas for these expenses as they were incurred. On receipt of each payment, Cooper Tire required that Maza sign a "Receipt and Subrogation Agreement" releasing Cooper Tire from all claims for the reimbursed expenses and acknowledging Cooper Tire's subrogation rights.[2]

In August 1989, Maza filed a medical malpractice action against Dr. Pillsbury, his wife's physician, in Arkansas state court. Maza sued Dr. Pillsbury individually

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[2] Both Maza and the Director of Labor Relations at Cooper Tire testified that Maza signed a Receipt and Subrogation Agreement each time medical bills were paid on his wife's behalf. App. at 195, 279. Only two of the agreements (representing $57,770.09 in payments) are in the record before us. Id. at 419-420. Based on the undisputed testimony of the Director that the agreements in the record are "exemplars" of the agreements signed for each and every payment, we will assume that the relevant language in all the agreements is identical. The two agreements in the record are identical, except for the insertion of relevant dates and amounts. One of these agreements is reproduced in the appendix to this opinion.

and on behalf of his wife's estate, alleging that his wife's death was the result of Dr. Pillsbury's negligence. On his own behalf, Maza sought recovery for medical expenses incurred and for loss of "consortium, society, and companionship." On behalf of the estate, Maza sought recovery of damages for medical expenses, loss of earnings, pain and suffering, mental anguish, and wrongful death. As Dr. Pillsbury's malpractice insurer, St. Paul provided for Pillsbury's legal defense.

In February 1990, Cooper Tire intervened in the state court action based on its payment of the Mazas' medical expenses. As discovery in the case progressed, both Maza and Cooper Tire discussed separate settlements with Dr. Pillsbury. By October 1990, Maza had reached a settlement with Dr. Pillsbury as to all the claims asserted by Maza and the estate except Cooper Tire's claim for medical expenses. Rather than wait for a settlement to be reached on the medical expenses claim, Maza and Dr. Pillsbury entered into a settlement agreement covering all the malpractice claims except Cooper Tire's alleged subrogation claim.

In exchange for $350,000, Maza and the estate released Dr. Pillsbury from all claims, but expressly reserved the "subrogation and other rights of Cooper."[3] Though there

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[3] The "Addendum to Release and Settlement Agreement" executed by Maza provides in relevant part: "It is expressly understood that the subrogation and other rights of Cooper as provided by the Plan and the Receipt and Subrogation Agreement is [sic] reserved and this settlement and release is not intended by the parties to in any way effect such subrogation and other rights of Cooper." App. at 430. Similarly, the order of dismissal entered in the state court

is evidence that Cooper Tire was aware that a separate settlement between Maza and Dr. Pillsbury was "imminent," Cooper Tire was not involved in the proceedings whereby both the probate court and the state trial court approved the separate settlement. On October 22, 1990, the state court dismissed Maza's complaint with prejudice.

After the settlement, Cooper Tire continued to pursue its claim in state court. Soon thereafter, however, it adopted a new strategy.[4] On May 8, 1991, Cooper Tire filed the present act federal district court against Maza, Dr. Pillsbury, and St. Paul, seeking to recover its claim for medical expenses out of the $350,000 settlement received by Maza and the estate. Cooper Tire contends that Maza breached the terms of the Plan and the Receipt and Subrogation Agreements by settling around its subrogation claim. As to Dr. Pillsbury and St. Paul, Cooper Tire alleges that they tortiously interfered with the contractual relationship between Maza and Cooper Tire by settling Maza's claims.

After a bench trial, the district court determined that Maza breached its contractual obligations to Cooper Tire. Though the court recognized that Cooper Tire still had the right to pursue a claim against Dr. Pillsbury, it found that the separate settlement impaired Cooper Tire's rights. The court

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action provides: "The intervention of Cooper Tire and Rubber Company is reserved and this dismissal is not intended to in any way effect the claims alleged in the intervention." Id. at 594.

[4] On Cooper Tire's motion, the Arkansas state court action was dismissed without prejudice on November 16, 1992.

focused primarily on Maza's failure to obtain Cooper Tire's written consent prior to any settlement, as required, according to Cooper, by the Receipt and Subrogation Agreements.[5] In the district court's view, Maza thereby stripped Cooper Tire of its right to block a separate settlement. The court also noted that Maza's conduct deprived the Plan of "the considerable benefit of having the injured employee act as the party plaintiff in a trial against the tortfeasor."

Cooper Tire & Rubber Co. v. St. Paul Fire and Marine Ins. Co., No. 91-1156, mem. op. at 14 (W.D. Ark. Oct. 1, 1993).

As to Dr. Pillsbury and St. Paul, the court found that they had intentionally interfered with the Maza-Cooper Tire contract. Applying Arkansas law, the court found that: 1) a valid contract existed between Maza and Cooper Tire; 2) Dr. Pillsbury and St. Paul knew of the contract; 3) Dr.

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[5] The relevant portion of the Receipt and Subrogation Agreement provides:

> Warranted no settlement has been made by the undersigned (Maza) with any person or corporation against whom a claim may lie, and no release has been given to anyone responsible for the loss, and that no such settlement will be made nor release given by the undersigned without the written consent of the said Cooper Tire & Rubber Company . . . .

App. at 420.

Pillsbury and St. Paul knew that a settlement with Maza would harm the rights of Cooper Tire; and 4) Cooper Tire suffered damage as a result.

Based on these findings, the court imposed joint and several liability on Maza, Dr. Pillsbury, and St. Paul for the amount of the medical expenses paid by Cooper Tire ($298,118.07) plus prejudgment interest ($53,661.25). The court denied Cooper Tire's request for attorneys' fees. Maza, Dr. Pillsbury, and St. Paul (collectively "Defendants") appeal from the judgment. Cooper Tire cross-appeals from the district court's denial of attorneys' fees.

II. DISCUSSION

In this appeal from a civil bench trial, we review the trial court's findings of fact for clear error. Its conclusions of law are subject to de novo review. Mixed questions of law and fact that require the consideration of legal concepts and the exercise of judgment about the values underlying legal principles are also reviewed de novo. See Ellis v. Great-West Life Assurance Co., No. 93-1973, 1994 WL 710466, at *4 (8th Cir. Dec. 23, 1994).

Defendants contend on appeal that the district court erred in failing to apply federal common law estoppel principles. They argue that Cooper Tire is estopped from bringing this action as a result of its willing participation in separate settlement negotiations and its initial acquiescence in the Maza-Pillsbury settlement. We need not address this argument. Both the parties and the district court have underestimated the impact of ERISA on Cooper Tire's

claims. Viewed in the context of the ERISA civil enforcement scheme, Cooper Tire's claims fail.

Our analysis focuses on Cooper Tire's claim against Maza. Cooper Tire styles the claim as an action for breach of the Plan and the Receipt and Subrogation Agreements. This claim must be based on a specific ERISA provision.[6] The broad preemptive sweep of ERISA limits Cooper Tire to the civil remedies contained in 29 U.S.C. § 1132(a). Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 54-57 (1987); Kuhl v. Lincoln Nat'l Health Plan, 999 F.2d 298, 302-04 (8th Cir. 1993), cert. denied, 114 S.Ct. 694 (1994). Otherwise, "the policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined. . . ." Pilot Life, 481 U.S. at 54.

Section 1132 (a) of ERISA provides that certain civil actions may be brought by a "participant," "beneficiary," or "fiduciary." As the administrator of its own plan, Cooper Tire qualities as a fiduciary, see 29 U.S.C. §1002(21)(A), but not as a participant or beneficiary, see id. § 1002(7)-(8). The remedies available to a fiduciary are set forth in section 1132(a)(3), which provides that a civil action may be brought:

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[6] Based on Cooper Tire's complaint and the district court's memorandum opinion, neither Cooper Tire nor the district court directly linked the claim to a specific ERISA provision. However, in a separate opinion denying Cooper Tire attorneys' fees, the district court noted that such fees are allowable "since this is a civil action brought by a fiduciary to enforce the terms of the plan. See 29 U.S.C. § 1132(a)(3) and 29 U.S.C. § 1132(g)(1)." App. at 133.

> (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan.

In order to obtain relief[7] under this provision, Cooper Tire must establish that Maza has failed to comply with the terms of the statute or the Plan. As noted above, the district court imposed liability based on Maza's failure to comply with the terms of the Receipt and Subrogation Agreements. Failure to comply with these agreements does not result in liability under section 1132(a)(3).

Section 1132(a)(3) requires a showing that the terms of the applicable ERISA plan have been violated. The Receipt and Subrogation Agreements are not part of Cooper Tire's Plan. They were executed after the covered medical expenses had been incurred and at a time when Maza already had a right to the benefits. See Sturges v. Hy-Vee Employee Benefit Plan and Trust, 991 F.2d 479, 481 (8th Cir. 1993) (per curiam) (finding plan revisions made after the occurrence of a covered event to be inapplicable to the participant). Cooper Tire is bound by the terms of the Plan in effect at the time the Mazas incurred the covered medical expenses. After a covered event has occurred, a plan

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[7] Cooper Tire does not seek an injunction pursuant to section 1132(a)(3)(A). Under 1132(a)(3)(B), Cooper Tire is entitled only to "appropriate equitable relief." Based on our resolution of this case, we do not reach the issue of whether the relief awarded by the district court was "equitable relief."

administrator cannot create new rights in a separate document and enforce those rights under ERISA.[8]

Thus, to determine the validity of Cooper Tire's claim against Maza, we must look to the terms of the Plan itself. The relevant language is contained in Article 12(e) of the Plan and can be broken down into three parts. First, it provides that Cooper Tire "will upon making payment [for a covered service or prescription drug] under this Plan succeed to any rights of recovery the Employee or dependent may have or acquire (with respect to such service or prescription drug) against any person or organization . . . ." Second, an employee who accepts payments under the Plan is required "to furnish such information and assistance, and execute such assignment[s] and other instruments as [Cooper Tire] may reasonably request to facilitate enforcement of the successor rights of [Cooper Tire]." Finally, the employees and their dependents are directed to "take no action prejudicing" Cooper Tire's subrogation rights.[9]

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[8] Indeed, the Receipt and Subrogation Agreements recognize this limitation. Each Agreement provides: "This Receipt and Subrogation Agreement is subject to the provisions of Article 12, Section E of Cooper Salaried Employees Medical Benefits . . . ." App. at 420. Article 12(e) contains the Plan's subrogation provisions.

[9] Article 12(e) of the Plan provides as follows:

> In the event an Employee or a dependent of an Employee, including the surviving spouse or a surviving dependent of a deceased Employee, is legally entitled to recover, including recovery under uninsured motorist coverage, all or a portion of the cost of a

The Plan gives Cooper Tire the power to "construe and interpret" the provisions of the Plan. Cooper Tire's interpretation of Article 12(e) is evident from its arguments in this appeal and from the Receipt and Subrogation Agreements. Essentially, Cooper Tire contends that the Plan language gives it: 1) subrogation rights as to all claims (not just medical expense claims) against any party liable for medical expenses; 2) the right to demand written consent prior to settlement of any claim against any party liable for

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> service or prescription drug covered by this Plan from a third party, the Company will upon making payment under this Plan succeed to any rights of recovery the Employee or dependent may have or acquire (with respect to such service or prescription drug) against any person or organization except insurors [sic] of individual hospital, surgical, or medical policies issued to the Employee or dependent.
>
> Employees (including dependents, surviving spouses or surviving dependents of deceased Employees) by acceptance of such benefit payments agree to furnish such information and assistance, and execute such assignment and other instruments as the Company may reasonably request to facilitate enforcement of the successor rights of the Company. Employees and their dependents shall take no action prejudicing such rights of the Company.

App. at 498.

medical expenses; and 3) the right to first-dollar recovery out of any settlement if written consent is not obtained.[10]

We review an administrator's interpretation of the Plan language under an "abuse of discretion" standard. Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115 (1989); Kennedy v. Georgia-Pacific Corp., 31 F. 3d 606, 609 (8th Cir. 1994). In so doing, we examine: 1) whether

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[10] The portions of the Receipt and Subrogation Agreements that reflect this interpretation provide in relevant part:

> [T]he undersigned [Maza] hereby subrogates said Cooper Tire & Rubber Company, to all of the rights, claims and interest which the undersigned may have against any person or corporation liable for the loss mentioned above . . .
>
> Warranted no settlement has been made by the undersigned with any person or corporation against whom a claim may lie, and no release has been given to anyone responsible for the loss, and that no such settlement will be made nor release given by the undersigned without the written consent of the said Cooper Tire & Rubber Company . . . .

App. at 420. Though we believe these provisions can be reasonably read to apply only to claims involving medical expenses, Cooper Tire's arguments on appeal make clear that it interprets this language broadly to apply to all claims against a party liable for medical expenses.

the interpretation is consistent with the goals of the Plan; 2) whether it renders any language in the Plan meaningless or internally inconsistent; 3) whether it conflicts with the substantive or procedural requirements of the ERISA statute; 4) whether Cooper Tire has interpreted the provision at issue consistently; and 5) whether the interpretation is contrary to the clear language of the Plan. Finley v. Special Agents Mut. Benefit Ass'n, 957 F.2d 617, 621 (8th Cir. 1992).

Based on the limited record before us, we are not prepared to find that Cooper Tire's interpretation of the Plan is inconsistent with the Plan's goals. Likewise, Cooper Tire's interpretation does not render any of the Plan language itself internally inconsistent. Nonetheless, the remaining factors persuade us that Cooper Tire has abused its discretion by so broadly interpreting the scope of Article 12(e).

First, the Plan conflicts with the ERISA requirement that the summary plan description (SPD) be "sufficiently accurate and comprehensive to reasonably apprise [the] participants and beneficiaries of their rights and obligations under the plan." 29 U.S.C. § 1022(a)(1). Cooper Tire's SPD fails to inform participants that Cooper Tire will claim a right to written consent or first-dollar recovery on all the participant's claims against a liable third party. Indeed, the SPD does not even mention subrogation rights. Thus, it does not support Cooper Tire's interpretation. See Lutheran Medical Ctr. v. Contractors, Laborers, Teamsters and Eng'rs Health and Welfare Plan, 25 F.3d 616, 621 (8th Cir. 1994).

In addition, there is evidence that Cooper Tire has interpreted the subrogation provision inconsistently. In a

1980 letter to Maza explaining the subrogation provisions in the Plan, Cooper Tire wrote:

> The Subrogation Section permits Cooper to be reimbursed from any liable third party for medical expenses incurred, as the result of an accident, by an employee or eligible spouse or dependent. A liable third party may be the party at fault, his/her Insurance Company or, when appropriate, your Uninsured Motorist Coverage. Under this paragraph you will be asked to sign an Agreement that allows Cooper to collect from the liable third party, then Cooper's Medical Plan will pay all medical costs that are covered by the plan.

App. at 422. This letter does not state, or even imply, that the subrogation provisions give Cooper Tire rights in claims other than those for medical expenses.

Most importantly, we find Cooper Tire's interpretation to be contrary to the plain language of the Plan. Cooper Tire's subrogation rights are expressly limited to Maza's right to recovery of medical expenses. Per the language of the Plan, Cooper Tire "succeeds" only to rights of recovery an employee or dependent may have "with respect to" services or drugs covered by the Plan. Thus, Cooper Tire's subrogation rights do not extend beyond its claim for medical expenses. Given this limitation, Cooper Tire may not demand written consent prior to settlement of non-medical expense claims and characterize it as a means to "facilitate enforcement" of its subrogation rights.

In sum, we find Cooper Tire's interpretation of the Plan's subrogation provisions to be an abuse of discretion. Reasonably interpreted, the Plan gives Cooper Tire subrogation rights only with respect to the medical expenses it paid on Maza's behalf. This being the case, there is no evidence that Maza took any actions which impaired Cooper Tire's subrogation rights. Cooper Tire still has the right to pursue its claim for medical expenses against Dr. Pillsbury. This right was expressly reserved by the Maza-Pillsbury settlement agreement and by the dismissal order of the Arkansas state court. In addition, Cooper Tire still has the right to pursue its claim in Maza's name.[11]

Thus, there is no evidence that Maza's conduct violated the terms of the Plan and he cannot be held liable under section 1132(a)(3). In the absence of any violation of Cooper Tire's rights, the state law tortious interference claim against Dr. Pillsbury and St. Paul fails and we need not consider whether it is preempted by ERISA. Cooper Tire's motion to assess attorneys' fees is moot and the district court's denial of the motion must be affirmed.

III. CONCLUSION

For the foregoing reasons, the order of the district court is reversed and this action is remanded with directions to dismiss Cooper Tire's claims against St. Paul Fire and

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[11] "Article 12(e) of the Plan requires Maza to furnish assistance which Cooper Tire may "reasonably request to facilitate enforcement" of its rights. It is reasonable to interpret this language to allow Cooper Tire to sue in Maza's name to recover the medical expenses it has paid.

Marine Insurance Company, Richard C. Pillsbury, M.D., and Robert Maza. The district court's denial of Cooper Tire's motion for attorneys' fees is affirmed.

A true copy.

Attest:
CLERK, U. S. COURT OF APPEALS
EIGHTH CIRCUIT.

Appendix

RECEIPT AND SUBROGATION AGREEMENT

The undersigned hereby acknowledges RECEIPT from the Cooper Tire & Rubber Company of the sum of One thousand six hundred and 00/100 Dollars ($1600.00) in full settlement of all claims and demands of the undersigned and any spouse or dependents of the undersigned for any medical costs, expenses or any other items whatsoever payable under the Cooper Tire Medical Payment Plan with regard to any accident, illness, or injury commencing on or about the 23rd day of June, 1988, or any medical treatment or services rendered during the period commending on or about the 3rd day of October, 1988, and ending on or about the 30th day of November, 1988.

In consideration of and to the extent of said payment the undersigned hereby subrogates said Cooper Tire & Rubber Company, to all of the rights, claims and interest which the undersigned may have against any person or corporation liable for the loss mentioned above, and authorizes the said Cooper Tire & Rubber Company to sue, compromise or settle in the undersigned's name or otherwise all such claims and to execute and sign releases and acquittances and endorse checks or drafts given in settlement of such claims in the name of the undersigned, with the same force and effect as if the undersigned executed or endorsed them.

Warranted no settlement has been made by the undersigned with any person or corporation against whom a claim may lie, and no release has been given to anyone

responsible for the loss, and that no such settlement will be made nor release given by the undersigned without the written consent of said Cooper Tire & Rubber Company and the undersigned covenants and agrees to cooperate fully (and to exert his best efforts to cause any affected spouse or dependent to cooperate fully) with said Cooper Tire & Rubber Company in the prosecution of such claims, and to procure and furnish all papers and documents necessary in such proceedings and to attend court and testify (and to exert his best efforts to cause any affected spouse or dependent to attend court and testify) if Cooper Tire & Rubber Company deems such to be necessary, but it is understood the undersigned is to be saved harmless from costs in such proceedings.

This RECEIPT AND SUBROGATION AGREEMENT is subject to the provisions of Article 12, Section E of Cooper Salaried Employees Medical Benefits, effective 1/1/86.

UNITED STATES COURT OF APPEALS
FOR THE EIGHTH DISTRICT

No. 94-2183WAED
No. 94-2209WAED
No. 94-2240WAED

Cooper Tire & Rubber Company,	*	
Appellee,	*	
vs.	*	Order Denying Petition for Rehearing and Suggestion for Rehearing En Banc
St. Paul Fire and Marine Insurance Company, et al.,	*	
Appellants.	*	

The suggestion for rehearing en banc is denied. Judge McMillian would grant the suggestion for rehearing en banc. The petition for rehearing by the panel is also denied.

April 25, 1995

Order Entered at the Direction of the Court:
Clerk, U.S. Court of Appeals, Eighth Circuit

UNITED STATES COURT OF APPEALS
FOR THE EIGHTH DISTRICT

No. 94-2183WAED
No. 94-2209WAED
No. 94-2240WAED

Cooper Tire & Rubber Company,	*	
Appellee,	*	
vs.	*	Appeal from the United States District Court for the Western District of Arkansas
St. Paul Fire and Marine Insurance Company; Richard C. Pillsbury, M.D.; Richard Maza,	*	
Appellants.	*	

On its own motion, the court orders a technical correction to its opinion of February 27, 1995. In the second full paragraph on page eleven, the opinion states, "Indeed, the SPD does not even mention subrogation rights." This portion of the opinion is hereby deleted.

May 2, 1995

Order Entered at the Direction of the Court:
Clerk, U.S. Court of Appeals, Eighth Circuit.

IN THE UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF ARKANSAS
EL DORADO DIVISION

COOPER TIRE & RUBBER COMPANY PLAINTIFF

V. NO. 91-1156

ST. PAUL FIRE AND MARINE
INSURANCE COMPANY et al. DEFENDANTS

MEMORANDUM OPINION

Trial to the Court on this matter was hold on September 14, 1993. At the conclusion of the trial, the Court advised the parties that it would take the matter under advisement. The Court hereby renders its opinion, based upon the pleadings now before it and the testimony and evidence received during the course of the trial.

PROCEDURAL BACKGROUND

In its complaint, plaintiff, Cooper Tire it Rubber Company ("Cooper Tire") brings suit in its capacity as a provider of medical benefits under an Employee Welfare Benefit Plan ("Plan") under 29 U.S.C. Section 1002. Jurisdiction is based upon diversity of citizenship and 29 U.S.C. Section 1001-1461 ("ERISA"). Plaintiff contends that it was entitled to recover from Robert Maza ("Maza") all sums received by him from St. Paul Fire & Marine Insurance

Companies ("St. Paul") and/or Richard C. Pillsbury, M.D. ("Pillsbury"), and the failure of Maza to pay over said funds to plaintiff constitutes breach of the contract. Plaintiff further alleges that St. Paul and/or Pillsbury, intentionally interfered with the existing contractual relations between Cooper Tire and Maza. Plaintiff seeks to recover from defendants, jointly and severally, the amount paid by it on behalf of the Mazas. Plaintiff also seeks reasonable attorney's fees, punitive damages, pre-judgment interest, post-judgment interest, and costs.

It is not disputed that as an employee of Cooper Tire, defendant Maza applied for and received medical benefits as a result of the illness of his deceased wife, Sandra Maza which commenced on or about June 23, 1988, and continued until she expired on December 4, 1988. It is likewise not disputed that under its employee health care plan, Cooper Tire paid, on behalf of Robert Maza and Sandra Maza, medical expenses in the sum of Two Hundred Ninety-Eight Thousand One Hundred Eighteen and 07/100 Dollars ($298,118.07).

Paragraph 12(e) of the Plan provides:

> In the event an Employee or dependent of an Employee, including the surviving spouse or a surviving dependent of a deceased Employee, is legally entitled to recover, including recovery under uninsured motorist coverage, all or a portion of the cost of a service or proscription drug covered by this Plan from a third party, the Company will upon making payment under this Plan succeed

> to any rights of recovery the Employee or dependent may have or acquire (with respect to such service or prescription drug) against any person or organization except insurers of individual hospital, surgical, or medical policies issued to the Employee or dependent.
>
> Employees (including dependents, surviving spouses or surviving dependents of deceased Employees) by acceptance of such benefit payments agree to furnish such information and assistance, and execute such assignment and other instruments as the Company may reasonably request to facilitate enforcement of the successor rights of the Company. Employees and their dependents shall take no action prejudicing such rights of the Company. (Emphasis added)

Two different Receipt and Subrogation Agreements were signed by defendant Maza - one on October 13, 1988 and one on January 19, 1990 - prior to the payment of the medical bills which were presented to Cooper Tire. In both documents, Maza agrees as follows:

> In consideration of any to the extent of said payment the undersigned hereby subrogates said Cooper Tire & Rubber Company, to all of the rights, claims and interest which the undersigned may have against any person or corporation liable for the loss mentioned above, and authorizes the said Cooper Tire & Rubber Company to sue,

compromise or settle in the undersigned's name or otherwise all such claims and to execute and sign releases and acquittances and endorse checks or drafts given in settlement of such claims in the name of the undersigned, with the same force and effect as if the undersigned executed or endorsed them.

Warranted no settlement has been made by the undersigned with any person or corporation against whom a claim may lie, and no release has been given to anyone responsible for the loss, and that no such settlement will be made nor release given by the undersigned without the written consent of the said Cooper Tire & Rubber Company and the undersigned covenants and agrees to cooperate fully (and to exert his best efforts to cause any affected spouse or dependent to cooperate fully) with said Cooper Tire & Rubber Company in the prosecution of such claims, and to procure and furnish all papers and documents necessary in such proceedings and to attend court and testify (and to exert his best efforts to cause any affected spouse or dependent to attend court and testify) if Cooper Tire & Rubber Company deems such to be necessary but it is understood the undersigned is to be saved harmless from costs in such proceedings. (Emphasis added)

On August 30, 1989, Maza, individually and as administrator of the estate of Sandra Maza, deceased, filed

suit in the Circuit Court of Union County, Arkansas, against defendant Pillsbury, for medical negligence resulting in the wrongful death of his wife, Sandra Maza. Pillsbury was insured by St. Paul, and pursuant to its policy with Pillsbury, St. Paul provided legal defense to Pillsbury.

Cooper Tire intervened in the state court action in a timely and proper fashion.

In its Motion to Intervene filed in the state court action, Cooper Tire stated that under the laws of the state of Arkansas, it is entitled to subrogate to the rights of the plaintiff, Robert Maza individually and as administrator of the estate of Sandra Maza, deceased,

> against any recovery he might have against the defendant herein to the extent of the amount paid by this petitioner; petitioner should be allowed to intervene in this cause so as to protect its subrogation rights and should be declared to have a first and paramount lien on the proceeds of any settlement, judgment or recovery made or rendered by, for or on behalf of said plaintiff or plaintiffs to the extent of the benefits paid or to be paid in the future.

In the Intervention Complaint, Cooper Tire made the same request, adding that the benefits paid or to be paid in the future thus far total $298,118.07.

On October 15, 1990, Maza filed in the state court action a Petition for Authority to Settle Wrongful Death

Claim. In the petition, Maza states that there has been offered "a reasonable sum in full and complete settlement of the wrongful death claim, and all claims, demands, and causes of action which have arisen or may arise from the accidental death of the decadent." The petition further states:

> By making such offer neither the Medical Center of South Arkansas nor Dr. Richard C. Pillsbury admit or acknowledge any fault or negligence on their part and, to the contrary, they specifically deny same.
>
> 4. As a condition of the offer there is an agreement of confidentiality and nondisclosure of the terms thereof.

Paragraph 6 of the petition states:

> Petitioner should be authorized to accept such offer and to execute and deliver any and all documents, instruments, or releases necessary to fully accept said offer and dismiss with prejudice the wrongful death action now pending in the Union County Circuit Court, second division, provided, however, that the intervention of Cooper Tire and Rubber Company is to be expressly reserved and the dismissal is not intended to in any way effect [sic] the claims as alleged in the intervention. (Emphasis added)

On October 17, 1990, the Release and Settlement agreement was signed by Maza. Therein, Maza released

Pillsbury and St. Paul from liability for all damages as follows:

> FOR THE SOLE CONSIDERATION of the payment of the sum of $350,000.00 (Three Hundred Fifty Thousand and no/100 Dollars) ... do hereby release, acquit, and forever discharge Dr. Richard C. Pillsbury... and St. Paul Fire and Marine Insurance Company ... from any and all actions, causes of action, actions for medical injury under Acts of Arkansas No. 709, 1979, as amended, claims, and demands, damages, costs, loss of services, expenses, and compensation, on account of or in any way growing out of any and all known and unknown personal injuries or death for or because of any matter or thing done, omitted or suffered to be done by the said parties herein released, prior to and including the date hereof, and particularly on account of the care, treatment or services of any kind rendered to Sandra Maza.
>
> * * *
>
> For the same consideration and as a part of this payment, the undersigned, Robert Maza.... further agree to indemnify and forever save harmless Dr. Richard C. Pillsbury.... and St. Paul Fire and marine Insurance Company... from any further claims or causes of action of any nature, demands, costs, attorneys' fees, expenses or judgments which might be incurred by or against them or any of them related to the care, treatment or

services of any kind rendered to Sandra Maza, except, however, as to the subrogation and other rights of Cooper Tire and Rubber Company as expressly reserved in the Addendum to Release and Settlement Agreement. (Emphasis added)

Maza also agreed, inter alia:,

to indemnify and forever save harmless Dr. Richard C. Pillsbury, Medical Center of South Arkansas, and St. Paul fire and Marine Insurance Company (as insurer of Dr. Richard C. Pillsbury, and Medical Center of south Arkansas) and any other physician, nurse, and medical care provider practicing at El Dorado, Arkansas, or in the Medical center of South Arkansas during 1988 and thereafter and their agents, servants and employee, and all other persons, firms and corporations of and from any further claims or causes of action of any nature, demands, costs, attorneys' fees, expenses or judgments which might be incurred by or against them or any of them related to the care, treatment or services of any kind rendered to Sandra Maza, except, however, as to the subrogation and other rights of Cooper Tire and Rubber Company as expressly reserved in the Addendum To Release and Settlement Agreement. (Emphasis added)

On October 17, 1990, an Addendum to Release and Settlement Agreement was signed by Maza, which states, inter alia:

> * * *In accordance with the Plan, and upon making payment, Cooper succeeds to any right of recovery the employee or dependent may have (with respect to cost of a service or prescription) against any person or organization. At the time of the payment Robert Maza executed a receipt and subrogation agreement by which Cooper was subrogated to all claims for medical costs, expenses or other items payable under the plan. It is expressly understood that the subrogation and other rights of Cooper as provided by the Plan and the receipt and Subrogation Agreement is reserved and this settlement and release is not intended by the parties to in any way effect such subrogation and other rights of Cooper. (Emphasis added)

On October 22, 1990, an order was entered by the state court judge dismissing with prejudice Maza's complaint against Pillsbury and St. Paul. The order specifically stated that the intervention of Cooper Tire "is reserved and this dismissal is not intended to in any way effect the claims alleged in the intervention."

On May 9, 1991, Cooper Tire brought the suit now before this Court against Maza, Pillsbury, and St. Paul.

On November 20, 1992, upon Cooper Tire's motion, the state court judge dismissed the intervention compliant without prejudice.

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

1. It does not appear to be disputed that plaintiff's claims are governed by the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. §1001, et. seq. It has also been held that ERISA applies to self-funded benefit plans and preempts application of state anti-subrogation laws. FMC Corp. v. Holliday, 498 U.S. 52 (1990). See Provident-Life & Acc. Ins. Co. v. Linthicum, 930 F.2d 14 (8th Cir. 1991); Baxter v. Lynn, 886 F.2d 182 (8th Cir. 1989).

2. Where federal case law does not deal with a dispute arising under a given issue, the Court must develop federal common law,, and will look to the plan contract itself, the statutory policies of ERISA and state law. Provident Life and Acc. Ins. Co. v. Waller, 906 P.2d 985, 993 (4th Cir. 1990), cert. denied, 498 U.S. 982 (1990).

3. The claims asserted by plaintiff in this case exist by virtue of the subrogation provision set forth in the Plan and Receipt and Subrogation Agreements referred to above. The Court recognizes it is not alleged that plaintiff Is right to proceed in a separate lawsuit against the tortfeasor has been defeated by the settlement agreement. The issues for the Court to determine are whether Maza breached the terms of the Subrogation Agreement by settling with Pillsbury without Cooper Tire's written consent and whether

St. Paul and Pillsbury interfered with the contractual relationship between Maza and Cooper Tire.

4. Jim Geers, Corporate Director of Labor Relations for Cooper Tire since 1989 testified that the normal procedure his office follows when a claim is submitted is to review the claim and determine if there is a potential subrogation claim. If so, their legal department is notified. If the legal department determines a subrogation claim exists, Cooper Tire asks the employee to sign a Receipt and Subrogation Agreement so that Cooper Tire can safely pay the employee's medical bills and save the employee from creditors' harassment. He stated that the subrogation clause is in the plan to protect the company and its employees.

5. Mike Landers, the attorney who represented Cooper Tire during the state court proceedings, testified that prior to May 7, 1990, he had discussions with counsel for Maza regarding settlement and in February of 1990, he had discussions with counsel for Pillsbury and St. Paul about possible settlement. He also stated that he talked with counsel for Maza about whether Cooper Tire would share in litigation expenses in late February 1990. He testified that his perception was that Maza and Cooper Tire might try to settle separately. He stated that it would have been proper for Cooper Tire to settle without Maza's consent, but it would not have been proper for Maza to settle without Cooper's consent. He asked counsel for defendants about the legal ethics of settling around Cooper Tire and told counsel for Pillsbury he did not think it was proper. He stated that he had no notice of the settlement hearing and would have attended had he received notice.

6. Counsel for defendants Maza and Pillsbury and St. Paul testified at length regarding the ongoing negotiations between them and Cooper Tire which took place during the state court action. It is not disputed by either defendant that when the state court held a hearing on the approval of the settlement between Maza, Pillsbury, and St. Paul, no notice of said hearing was given to counsel for Cooper Tire, and it was not until after the settlement between Maza, Pillsbury, and St. Paul became final that counsel for Cooper Tire knew of said settlement. Defendants argue that counsel for Cooper Tire was aware of the negotiations between counsel for Maza and Pillsbury, and never voiced any objection to the settlement, raising the defense of estoppel. Further, defendants argue that they preserved Cooper Tire's subrogation rights in the Release and Settlement and Addendum to Release and Settlement. Defendants do not dispute the facts that no written consent was given by Cooper Tire to the settlement between Maza, Pillsbury, and St. Paul, as required by the Subrogation Agreement and that counsel for Cooper Tire was not given notice of the settlement hearing.

7. It is the Court's opinion that, by entering into the Settlement Agreement without the written consent of Cooper Tire, defendant Maza breached the terms of the Receipt and Subrogation Agreement. The Agreement stated that written consent was required by Cooper Tire before Maza could settle his case or give any release. The undisputed facts show that Cooper Tire's written consent was never requested nor given with respect to the said settlement.

Defendants take the position that the silence of counsel for Cooper Tire and his failure to voice any

objection to the settlement now estops Cooper Tire from making such objection. The Court is not persuaded by this argument. State law claims of estoppel have been held to be preempted under the terms of ERISA. See Rodrigue v. Western and Southern Life Ins. Co., 948 F.2d 969 (5th Cir. 1991); Agee v. Armour Foods Co., 672 F.Supp. 1210 (D. Mo. 1986), aff'd 834 F. 2d 144 (8th Cir. 1987) ; accord Barkdall v. H&W Motor Express Co., 820 F.Supp. 410 (D. Iowa 1993). Although in Fitch v. Arkansas Blue Cross and Blue Shield, 795 F.Supp. 904 (W.D. Ark. 1992), the court applied estoppel principles on a federal common law basis to an ERISA case, that case involved the situation where oral representations were made concerning ambiguities in the plan. The court held:

> Despite this language in Phillips, we do not believe the Court of Appeals for the Eighth Circuit bar [sic] the application of estoppel principles in all ERISA actions. Whatever the applicability of equitable estoppel claims in general under ERISA, the court believes equitable relief is proper under ERISA where the challenged actions do not involve alleged modifications of the plan.

Id. at 908.

See also, Kane v. Aetna Life Ins., 893 F.2d 1283 (11th Cir. 1990), cert. denied, 498 U.S. 890 (1990). In this case, the plan is clear as to both the recovery of the proceeds in the event of the recovery from a third party tortfeasor and the subrogation rights of Cooper Tire. The Court finds credible Mr. Landers' testimony that he was concerned and expressed

such concern to counsel for Maza and Pillsbury as to whether they could settle around Cooper Tire. Furthermore, there was no evidence presented which indicate that Landers, on behalf of Cooper Tire, in any way led defendants counsel to believe that written consent to a settlement would no be required. The Court believes that to allow applicability of the estoppel argument in this case would not comport with the underlying policy of ERISA, since it would violate the terms of the Plan and create further delay in potential recovery of the payment made under the Plan.

8. Defendants contend they preserved Cooper Tire's subrogation rights in the Settlement Agreement and, therefore, the settlement between Maza, Pillsbury, and St. Paul did not constitute a breach of the agreement which gave rise to those rights. However, a close reading of the documents in question indicates otherwise. In the Settlement Agreement, defendants expressly reserved Cooper Tire's subrogation rights and other rights. One of those "other rights" contained in the Subrogation Agreement was the right to effectively block a settlement by Maza by withholding written consent of same. Maza's act of settling without first obtaining the written consent of Cooper Tire concerning the settlement adversely affected Cooper Tire's "other rights".

One of the purposes in obtaining subrogation rights is to insure that when an individual Plaintiff who has been injured receives his money from the alleged tortfeasor, the insurer - in this case Cooper Tire - which has paid out its money quickly, will also be reimbursed quickly and will not have to spend large quantities of money and time pursuing litigation in its own behalf at a later time. In Keeton and

Widiss, Insurance Law, §3.10(c)(1988), this concern is addressed:

> When an Insurer asserting a right of subrogation, wants to initiate an action against a third party, the insurer usually prefers the controversy - especially when a jury may be involved - as one between the insured and third party. One justification for presenting such an action as the insured's claim is that this approach avoids the possible effect of prejudice an the part of jury members against insurers.
>
> The justification for permitting an insurer's subrogation action against a third party to be brought in the name of an insured is most persuasive when the insurer has paid only part of the loss, so that the insured continues to retain a beneficial interest in the claim.

Id. at 240-41, 244-45 (footnotes omitted).[1]

In the same treatise, the author addresses one of the remedies available:

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[1]The Arkansas case of Sentry Insurance Co. v. Stuart, 246 Ark. 680, 439 S.W.2d 797 (1969) was cited in the footnote. (medical payments coverage; trial court's action in sustaining demurrer reversed).

> The majority rule allows a subrogated insurer to proceed against a tortfeasor who settled with an insured in violation of the insurer's subrogation rights. Thus, a payment to an insured (or another) by a third party who knew of an insurer's subrogation interest does not discharge the third party's liability to the extent of the insurer's subrogation interest.
> ***
> When insurance benefits have been paid to the insured, a subrogated insurer may be entitled to enforce one or another among several possible remedies in a separate action against the insured. Causes of action, subject to some qualifications, have been recognized on each of the following theories:
>
> > (i) Breach of Contract. A settlement with a third party tortfeasor, responsible for the insured loss, constitutes a breath of an express subrogation provision included either in the insurance policy or in a collateral agreement (such as an assignment, "loan receipt," or subrogation agreement executed at the time of payment of the policy claim), and either damages are recovered for the breach or the insurer is entitled to predicate a denial of a claim for insurance benefits on the insured's breach.

Id. at 244-45 (footnotes omitted).

9. "Other rights" also held by Cooper Tire included the right to require Maza to cooperate by furnishing information, assistance, assignments or any other instruments needed to facilitate the enforcement as well as the right of Cooper Tire to settle on his behalf, including the power to endorse settlement checks or drafts and sign releases and acquittances in his own name. Defendants clearly recognized Cooper Tire's "other rights" since this language appears in the Settlement Agreement and Addendum.

10. Clearly, these other rights were not preserved by the settlement between Maza and Pillsbury. obviously the settlement agreement itself - reached and implemented without Cooper Tire's knowledge or written consent - violated rather than preserved Cooper Tire's right not to have that very thing happen. Moreover, it does not appear that there was ever any discussion among the settling parties as to what Cooper Tire's other rights were. It seems it was just assumed that all Cooper Tire had, by way of subrogation rights, was the right to sue the tortfeasor directly for reimbursement of medical expenses.

If the Court were to approve and sanction the type of settlement reached which disregards these other valuable rights, the resulting precedent would permit an injured employee to disregard his obligations under the ERISA plan and under the Receipt and Subrogation agreements and recover for his own benefit, subjecting the ERISA plan administrator to the whim of attorneys for the insured and tortfeasor to determine whether the Plan's rights are adequately protected. It would also require a Plan administrator to seek recovery by separate suit against the tortfeasor. Such a ruling only not only would condone a

breach of contract, but would also have the potential of adversely affecting the efficient and proper administration of the ERISA plan. As indicated in the insurance treatise quoted from above, such a precedent would place the plan" administrator in a position of paying for the medical bills quickly but not being able to be reimbursed quickly, and would further deprive the administrator of the considerable benefit of having the injured employee act as the party plaintiff in a trial against the tortfeasor. Additionally, as was found in Curtis v. Sears, Roebuck & Co., 754 F.2d 781 (8th Cir. 1985), Cooper Tire was in a position where its interest was impaired by disposition of the main claim without Cooper Tire's participation.[2] In Curtis, the Eighth Circuit stated:

> The lapse of time required to institute a now action and get service on Sears and Curtis could give Curtis time to leave the state, spend the money, or take other steps to impede State Farm's collection effort. Neither of the existing parties represents State Farm's interest. Curtis does not because he stands to lose what could be a potential double recovery if State Farm is allowed to remain in the action. Sears wants the action to end as soon as possible for fear of being expected to make a double payment. State Farm was therefore properly allowed to intervene as of right.

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[2]The Court recognizes distinctions that can be made between the present case and the Curtis case. However, the Court believes many of the principles announced in Curtis are applicable here.

Id. at 784.

11. Although the facts in this case are not as egregious as those in Daves v. Hartford Acc. and Indemn. Co., 302 Ark. 242, 788 S.W.2d 733 (1990), the Court finds certain language in that case to be pertinent:

> Prior to the settlement between Sentry and Daves, Hartford repeatedly notified Sentry of its subrogation claim. Thereafter, Sentry, with full knowledge of Hartford's interest, paid Daves pursuant to the settlement, without notifying Hartford of the settlement or Daves' suit, and then excluded Hartford's name from the settlement, prepared by Sentry, to indemnify Sentry for all claims "Hartford may make against Sentry by virtue of the medical PIP and subrogation lien that Hartford is making in this case."
>
> Obviously, from the wording in its agreement, Sentry's maneuvers were simply a well designed and calculated attempt to escape its acknowledged duty to Hartford. Under the circumstances, we hold that Sentry cannot legally or equitably ignore its responsibility to pay Hartford's lien even though it may have parted with the settlement proceeds through improvident payment to Daves.

Id., 302 Ark. at 249-50.

12. The Court does not suggest that counsel for Pillsbury and Maza schemed or manipulated so as to deny Cooper Tire the benefit of recovering its payments made on Maza's behalf. To the contrary, the testimony presented indicates that counsel for defendants in good faith thought the language contained in the settlement agreement and addendum preserved Cooper Tire's rights. However, as already stated, the Court believes Cooper Tire's rights consisted of more than the right to sue for and receive payment for medical expenses, and that defendants viewed Cooper Tire's rights too narrowly. These "other rights" were not, in the Court's opinion, preserved by the language in the Settlement Agreement and Addendum, and were violated when settlement occurred without Cooper Tire's written consent. Obviously, defendants Pillsbury, St. Paul, and Maza could not properly or legally just agree among themselves that Cooper Tire's written consent to the settlement was not required and expect Cooper Tire to be bound by that agreement or this Court to uphold it. Further, the fact that Cooper Tire tried to negotiate a settlement could not reasonably have been construed as an amendment to the agreement which would eliminate the right of "written consent". The subrogation agreement did not say written consent was required from Cooper Tire "unless its rights were preserved in the settlement agreement." The fact that defendants thought they were preserving Cooper Tire's rights becomes irrelevant when considering the express language of the documents in question. Therefore, the Court believes that Maza breached his agreement with Cooper Tire when he settled the claim without Cooper Tire's written consent and failed to reimburse plaintiff out of the funds.

13. The findings and conclusions mentioned above require the Court to further conclude that Pillsbury and St. Paul tortiously interfered with Maza's contract with Cooper Tire. In Arkansas, the elements of a prima facie case of tortious interference with contract are:

> (1) The existence of valid contractual relationship or business expectancy;
> (2) The knowledge of the relationship or expectancy on the part of the interferer;
> (3) Intentional interference inducing or causing a breach or termination of the relationship or expectancy; and
> (4) Resulting damage to the party whose relationship or expectancy has been disrupted.

Robertson Oil Co., Inc. v. Phillips Petroleum Co., 871 F.2d 1368, 1372 (8th Cir. 1989).

14. it is undisputed that a valid contractual relationship existed between Maza and Cooper Tire. Furthermore, by virtue of Cooper Tire's intervention in the state court action, defendants were aware of the Receipt and Subrogation Agreements between Maza and Cooper Tire. Although Maza testified he did not recall anyone from Cooper Tire explaining the Receipt and Subrogation Agreements to him, he nevertheless signed the documents and there was no evidence presented that he was coerced into doing so. He was merely told that he had to sign the agreement in order to have the plan pay his medical bills. Defendants were aware of Cooper Tire's expectancy to be paid, and were aware the Receipt and Subrogation Agreements existed between Cooper Tire and Maza.

Reference to the language contained in the Plan and Subrogation Agreement was made in the Second Amended complaint in Intervention, and defendants therefore had knowledge of the obligations set forth therein.

15. To be liable for tortious interference with a contract, one must either desire to bring about the harm to the plaintiff or have known that this result was substantially certain to be produced by his conduct. City National Bank of Fort Worth v. Unique Structures, Inc., 929 F.2d 1308, 1316 (8th Cir. 1991). The Court is of the opinion that Pillsbury and St. Paul knew at all times that, if they could settle their claim with Maza, they could reduce the settlement value of the claim with Cooper Tire. St. Paul obviously acted to protect its own economic interest by settling Maza's claim on the most favorable terms possible since by doing so, it could limit its remaining exposure and that of it insured to the amount of the medical expenses which had been paid by Cooper Tire. By entering into the settlement, St. Paul could eliminate the prospect of Pillsbury being exposed to any further personal liability.

16. Having found that plaintiff met its burden of proving the first three (3) elements of a prima facie case of tortious interference with contract, the Court will now address the resulting damage Cooper Tire has suffered. As a result of the interference with the contract between Cooper Tire and Maza, Cooper Tire has been stripped of its right to be associated with Maza in connection with a settlement and of its right to expect that when Maza gets his money, Cooper Tire will get its money. It should be obvious that of the two (2) claims - that of Maza as a bereaved widower, who lost his wife allegedly as a result of alleged medical malpractice

of one of the defendants, as opposed to the claim of Cooper Tire, a large business entity who is simply seeking reimbursement for dollars paid out - the former is by far more attractive to a jury and more potentially dangerous to defendants than is tho latter. It would logically follow, therefore, that if not settling the latter claim would prohibit the favorable settlement of the former claim, defendants would be more likely to settle the latter claim than they would if it were the only claim the defendants would have to consider. As conceded by plaintiff, such a strategic right is a loss which is difficult to place a value on, but the Court agrees that it is at least worth the value of the settlement with Robert Maza up to the amount Cooper Tire paid out for him and his wife on medical expenses occasioned by that same loss and the expense of enforcing its subrogation right, namely its attorney's fees and costs. As noted in the treatise cited above:

> If the objective of an insurer's cause of action is damages for breach of contract by the insured, troublesome questions may arise concerning the measure of damages. The insurer's rights depend to a large extent on views regarding the respective interests of the insured and the subrogated insurer in the third party claim.
>
> A conflicting line of precedents, which includes several variants, limits an insurer's relief to an amount that is consistent with the harm done by the breach. For example, in one leading case, the court stated that in order to prove the harm done by violation of its

subrogation rights an insurer "must show that in fact it might have recovered against* * *" the third party "as a wrongdoer." The insurer had issued collision coverage for a car and had a subrogation interest in the claim for damage to the car, but no interest in the insured's very substantial claim for personal injury. The use of the word "might" in this opinion is ambiguous. Was it intended to mean that in order to recover the insurer must show both that it would have litigated the tort claim and that it would have recovered judgment against the alleged tortfeasor if the settlement had not been made? Alternatively, is it sufficient for an insurer to show that the prospect of a suit would have been sufficient to have effected some recovery by way of compromise of the disputed liability? The second interpretation of what the insurer should be required to prove seems the fairest, because it is essentially comparable to the position the insurer would have occupied had the subrogation rights not been violated.

If the passage quoted in the preceding paragraph means that the insurer must prove that it would have recovered in the event the claim had been litigated rather than being settled, then the compromise settlement figure is not treated as the true value of the third party claim. If the passage means that the insurer must show only that there is such a possibility of a recovery because the claim had

> settlement value, then it would be open to the insurer to show damages in an amount equal to the compromise settlement figure allocable to the portion of the claim to which it was subrogated (the property damage claim, but not the personal injury claim). Although an insurer would be free to urge that the reasonable compromise settlement value exceeded the amount the insured accepted in settlement, the insured would have little cause for complaint if the insurer were satisfied to treat the actual settlement figure as the true value.

Keeton and Widiss, Insurance law §3.10 (1988) at p. 247.

17. As the Court stated from the bench, Fed.R.Evid. 408 provides that evidence of (1) furnishing or offering or promising to furnish, or (2) accepting or offering or promising to accept, a valuable consideration in compromising or attempting to compromise a claim which was disputed as to either validity or amount, is not admissible to prove liability for or invalidity of the claim or its amount. The Court further notes that under said rule, "Evidence of conduct or statements made in compromise negotiations is likewise not admissible. The rule also states that exclusion is not required when the evidence is offered for another purpose, such as proving bias or prejudice of a witness, negativing a contention of undue delay, or proving an effort to obstruct a criminal investigation or prosecution. The comments to the rule state that the rule excludes such evidence only when the purpose is proving the validity or

invalidity of the claim or its amount, and an offer for another purpose is not within the rule.

There is no question that the majority of the testimony at the trial in this case consisted of statements made during the settlement negotiations relative to the state court trial. However, the statements introduced in this trial were offered for the purpose of trying to prove defendant's estoppel theory - that plaintiff was aware that defendants were trying to settle separately with Maza and that it raised no objection thereto. In this case, both sides chose to offer the evidence of settlement negotiations, which, arguably was offered for a permissible purpose. Therefore, although the Court finds discussion of Rule 408 to be of limited relevance, the purpose behind the rule - to encourage freedom to communication with respect to compromise - has application in this case. To hold, solely, or at least in large part, on the basis of evidence of settlement negotiations, that defendants' conduct in this case did not constitute a breach or tortious interference would create a chilling effect on settlement negotiations.

Based upon the foregoing, the Court finds in favor of plaintiff and against defendants on both claims. In so holding, the Court finds that plaintiff should recover from defendants, jointly and severally, the amount of medical expenses paid $298,118.07. The Court also finds that plaintiff is entitled to recover attorney's fees and costs in this matter. If the parties are unable to reach an agreement as to

the amount of attorney's fees and costs, plaintiff should present its petition for such by October 15, 1993.

ENTERED this _____ day of _____ _____, 1993.

_____

JIMM LARRY HENDREN
UNITED STATES DISTRICT
JUDGE

IN THE UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF ARKANSAS
EL DORADO DIVISION

COOPER TIRE & RUBBER COMPANY PLAINTIFF

V. NO. 91-1156

ST. PAUL FIRE AND MARINE
INSURANCE COMPANY ET AL. DEFENDANTS

JUDGMENT

In accordance with the Memorandum Opinion filed this same date, the Court hereby enters judgment in favor of plaintiff and against defendants in the amount of $298,118.07, plus reasonable attorney's fees and costs, the amount which will be determined upon proper petition.

ENTERED this 1st day of October, 1993.

JIMM LARRY HENDREN
UNITED STATES DISTRICT
JUDGE

IN THE UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF ARKANSAS
EL DORADO DIVISION

COOPER TIRE & RUBBER COMPANY PLAINTIFF

V. NO. 91-1156

ST. PAUL FIRE & MARINE INSURANCE COMPANIES, ROBERT MAZA AND RICHARD C. PILLSBURY, M.D. DEFENDANTS

ORDER

NOW on this 12th day of April, 1994, comes on for consideration several post-trial motions: 1) Motion for New Trial and Amendment of Judgment filed by defendant Robert Maza ("Maza"); 2) Motion for New Trial filed by St. Paul Fire & Marine Insurance Companies and Richard C. Pillsbury, M.S. ("St. Paul and "Pillsbury"); 3) Motion for Assessment of Attorneys I Fees and Costs; and 4) Motion for Prejudgment interest. Responses and replies have been filed and the matters are now ripe for determination.

Motions for New Trial and Amendment of Judgment

In the "Argument" in support of his motion, defendant Maza states that the Court's opinion suggests that when the settlement was made by Maza, a $298,118.07 check should

have been written to Cooper Tire & Rubber Company, who had done very little to recover this money. Defendant complains that should the judgment stand, plaintiff will recover, without costs to them, the entire amount of their claim.

In the "Memorandum in Support of Motion for New Trial" filed by defendant St. Paul and Pillsbury, it is argued, in part, that "the 'chilling affect' of this Court's decision is that an employer under the guise of an ERISA right can completely dominate and dictate the course of a personal injury or wrongful death claim because of the employer's subrogation right for money expended under an employee benefit plan."

The Court believes that a reading of the opinion clearly suggests that prior to the settlement, Maza should have obtained Cooper Tire's written consent. Further, defendants fail to mention or recognize the fact that the Court based its decision on the very clear language contained in the Subrogation Agreements, both of which were signed by defendant Maza, who reaped the benefits by the Plan's payment of medical expenses. Defendants, St. Paul and Pillsbury, had knowledge of these documents, since they were part of the record in the state court decision. It is these documents which required Maza to obtain the written consent of plaintiff prior to finalizing any settlement agreement, which was not done in this case. Since defendants chose to ignore the clear language of the Subrogation Agreements with respect to the requirement of prior written consent by plaintiff before any settlement, one might reasonably expect that defendants would likewise fail to note or ignore the fact that the Subrogation Agreements say nothing whatever about

the deduction of costs and attorneys' fees from any recovery due plaintiff under the subrogation right. Finally, it is perhaps a bit brazen for defendant Maza to now argue that the Court should deduct an attorneys' fee from plaintiff's recovery when it appears that the settlement made was in knowing violation of plaintiff's contractual rights and that plaintiff has been required to bring this suit to enforce those rights.

As to defendants' argument that the opinion by this Court creates a "chilling effect." The Court believes that a "chilling effect" would result only if the Court had reached a contrary result, as indicated in the following language of the Court opinion.

> If the Court were to approve and sanction the type of settlement reached which disregards these other valuable rights, the resulting precedent would permit an injured employee to disregard his obligations under the ERISA plan and under the Receipt and Subrogation agreements and recover for his own benefit, subjecting the ERISA plan administrator to the whim of attorneys for the insured and tortfeasor to determine whether the Plan I s rights are adequately protected. It would also require a Plan administrator to seek recovery by separate suit against the tortfeasor. Such a ruling not only would condone a breach of contract, but would also have the potential of adversely affecting the efficient and proper administration of the ERISA plan. As indicated in the insurance

> treatise quoted from above, such a precedent would place the plan administrator in a position of paying for the medical bills quickly but not being able to be reimbursed quickly, and would further deprive the administrator of the considerable benefit of having the injured employee act as the party plaintiff in a trial against the tortfeasor....

The standard which has been applied by the Eighth Circuit in determining a motion for new trial is stated in White v. Pence, 961 F.2d 776 (8th Cir. 1992):

> With respect to motions for new trial on the question of whether the verdict is against the weight of the evidence, we have stated: "In determining whether a verdict is against the weight of the evidence, the trial court can rely on its own reading of the evidence-it can 'weigh the evidence, disbelieve witnesses, and grant a new trial even where there is substantial evidence to sustain the verdict. I" (citation omitted) . . . . These cases establish the fundamental procedures or methodology to be applied by the district court in considering new trial motions and are in contrast to those procedures governing motions for j.n.o.v.
> * * *
> It is apparent that this language in Fireman's Fund was discussing's verbal formulation of the quantum of weight to support the grant of a new trial, and while

reciting the terms 'clear weight,' 'overwhelming weight,' or 'great weight,' we made plain that the ultimate test was whether there had been a miscarriage of justice. We believe there is nothing inconsistent with the discussion of quantum in Fireman's Fund and the discussion of methodology in Brown, Bates, and Slaton, described above, and in Cole v. Williams, we essentially stated as much.

The district court's discretion is not boundless, however. We stated in Fireman's Fund and reiterated in Blake that the district court is not "'free to reweigh the evidence and set aside the jury verdict merely because the jury could have drawn different inferences or conclusions or because judges feel that other results are more reasonable.'" (citation omitted). We similarly observed in McGee v. South Pemiscot School Dist., 712 P.2d 339 (8th Cir. 1983), that the 'trial judge may not usurp the functions of a jury . . . [which] weighs the evidence and credibility of witnesses.' Id. at 344.

Fireman's Fund contains further discussion limiting the grant of a new trial. We there stated: 'Where the subject matter of the litigation is simple; where there exists no complicated evidence or where the legal principles presented are such that they would not confuse the jury, the court should be reluctant to grant a new trial.' 466 F.2d at 187. In this vein, and looking at the

> particular evidence before the court, we concluded: 'The evidence is such that reasonable men may differ as to the result, therefore, the determination should properly be left for the jury.' Id. We concluded that there was no significant weight factor favoring the defendant in that case, and reversed the grant of the new trial. The cases articulating this theme but underscore this distinction between such rulings and the judicial weighing and balancing required by the cases we have discussed above.

Id. at 780-781.

In their motion and briefs, defendants have presented substantially the same arguments that were presented to the Court prior to its ruling, and have failed to convince the Court that a miscarriage of justice has occurred by the Court's findings in this matter.

Defendant Maza spends little time in argument relating to the liability determination made by the Court, and then argues that the Court erred in the determination of damages. Defendant Maza argues that the plaintiff has not demonstrated a figure allocable to the medical claim because there was no recovery for the medical claim, which claim was allegedly preserved. He further argues that to award a judgment for the full amount of medical expenses without deducting any costs of collection and separating the medical expenses claim and personal injury claim is not compatible with the treatise cited.

Defendants St. Paul and Pillsbury argue that protecting their economic interests or the interest of Pillsbury is not sufficient evidence of tortious conduct to support a finding of intentional interference. Defendants also argue that plaintiff did not sustain its burden of proving there was resulting damage, and that the evidence of medical expenses paid fails to provide a basis upon which the Court could determine the amount of damages resulting from or proximately caused by the tortious interference.

The Court, in its opinion, set forth the elements required to be proven in a case involving a tortious interference with contract claim, and examined the evidence produced at the trial in light of those elements. As argued by plaintiff, defendants chose not to introduce any evidence on the issue of allocation of damages, relying entirely on the estoppel argument. Defendants failed to introduce any evidence relating to the value of Maza's entire claim. Finally, the Court is not persuaded by defendant's "privilege" argument. Defendant has failed to convince the Court that its conclusions were unfounded and the court hereby denies the Motions for Now Trial or Amendment of Judgment on the basis of the argument that the evidence does not support the opinion.

Motion for Assessment of Attorneys' Fees

In its opinion, the Court found that plaintiff "is entitled to recover attorney's fees and costs in this matter." Op. at p. 21. The Court also found that plaintiff's claims were governed by ERISA. Op. at p. 7. Plaintiff's counsel seeks $46,147.50 in attorneys' fees. Affidavits of the attorneys of record were submitted in support of the motion.

Defendants argue that there are no provisions for attorneys' fees, statutory or otherwise in this case. Alternatively, defendants ask that attorneys' fees be denied since plaintiff has not made the itemization of fees available to them.

First, the Court will address whether it may now give defendant relief from that portion of the judgment awarding attorneys' fees. Plaintiff argues that such a request is untimely and unwarranted under Fed. R. Civ. P. 59. However, under Rule 60(b), a party may obtain relief from a judgment or order in certain circumstances, including mistake or inadvertence. Mistake or inadvertence by the Court is included in said rule. Turner v. Secretary of Air Force, 944 F.2d 804, 807 (11th Cir. 1991). In this case, the Court is of the opinion that after conducting more thorough research with respect to the attorneys' fee issue, it was mistaken in awarding attorney's fees, and hereby relieves defendant from said part of the judgment for the following reasons:

An award of attorneys' fees would be allowable in this case since this is a civil action brought by a fiduciary to enforce the terms of the plan. See 29 U.S.C. §1132(a)(3) and 29 U.S.C. §1132(g)(1). However 29 U.S.C. §1132(g)(1) clearly gives the Court discretion ("The court in its discretion may allow a reasonable attorney's fee and costs of action to either party"). Said statute does not establish criteria directing the Court's determination of fee awards. However, as set forth in Andrews v. Employees' Retirement Plan of First Alabama Bancshares, 938 F.2d 1245, 1248 (11th Cir. 1991), the Court in Iron Workers Local No. 272 v. Bowen, 624 P.2d 1255, 1266 (5th Cir. 1980), adopted

five factors governing the district court's determination whether to award fees in an ERISA action:

> (1) the degree of the opposing parties' culpability or bad faith; (2) the ability of the opposing parties to satisfy an award of attorneys' fees; (3) whether an award of attorneys' fees against the opposing parties would deter other persons acting under similar circumstances; (4) whether the parties requesting attorneys' fees sought to benefit all participants and beneficiaries of an ERISA plan or to resolve a significant legal question regarding ERISA itself; and (5) the relative merits of the parties' positions.

Id. at 1248 (footnotes omitted).

The Court will address each of the above factors.

1. Although the Court has clearly hold that defendants were incorrect in their assumption that the preservation of Cooper Tire's rights in the settlement agreement adequately protected Cooper Tire, the Court cannot say that defendants acted in bad faith.

2. Although defendants St. Paul and Pillsbury may have the ability to pay an award, it is doubtful that defendant Maza has such ability. Further, the Court can not say that an award would dater other persons acting under similar circumstances. Defendants relied upon the advice of their counsel in agreeing to the terms of the settlement agreement, and it is therefore doubtful that an award in this

case would have any deterrent effect other than upon attorneys.

3. Although the outcome of the case benefits all participants and beneficiaries of the ERISA plan, the Court does not believe plaintiff's intent was to benefit all participants and beneficiaries or to resolve a legal question regarding ERISA itself.

4. This case was hotly contested and although the Court disagreed with defendants' positions, the Court does not believe their position was totally without merit.

After considering the above factors in light of the facts and circumstances in this case, the Court, in the exercise of its discretion, declines to award attorneys' fees and costs, and an Amended Judgment will be entered accordingly.

Prejudgment Interest

This Court has had occasion to recently address the issue of prejudgment interest in Missouri Pacific Railroad Company v. R.N. Reynolds Construction Co., Inc., no. 90-1004, in an Order entered on March 10, 1994, a copy of which is attached hereto. In that Order, the Court discussed at length the law relating to the. award of prejudgment interest as decided by the Arkansas courts and Eighth Circuit Court of Appeals. A review of that Order leads the Court to conclude that the case most on point with the facts presented herein is Bank of Mulberry v. Fireman's Fund Insurance Co., 720 F.2d 501 (8th Cir. 1983), where the bank brought action against an insurance company providing coverage

against losses resulting from employee fraud on claims which the insurer had denied. In reversing the district court's denial of prejudgment interest, the Eighth Circuit stated:

> Prejudgment interest is to be awarded in cases where there is a method of determination of the value of the property at the time of the loss. Lovell v. Marianna Federal Savings & Loan Ass'n, 267 Ark. 164, 589 S.W.2d 577 (1979). In Lovell, the court held that prejudgment interest should have been awarded when the property involved was a certificate of deposit. Prejudgment interest has also been awarded in cases involving a real estate broker's fee, Toney v. Haskins, 7 Ark. App. 98, 644 S.W.2d 622, 627 (1983); damage to an automobile, Wooten v. McClendon, 272 Ark. 61, 612 S.W.2d 105 (1981) and the cost of a construction job, United States v. United States Fidelity & Guaranty Co., 644 F.2d 747 (8th Cir. 1991) (applying Arkansas Law). Prejudgment interest has been denied in cases involving persona injuries, Wooten v. McClendon, 612 S.W.2d at 106; see Lovell v Marianna Federal Savings and Loan Ass'n, 589 S.W.2d at 578; and lost profits, Red Lobster Inns, Inc. v. Lawyers Title Ins. Co., 656 F.2d 381, 386 (8th Cir. 1981) (applying Arkansas law).
>
> It is not obvious from looking at these cases into which category payment of insurance proceeds should fall. However the premier

> prejudgment interest case in Arkansas, Lovell, provides some guidance. In that case the court noted that "[i]n the present case the certificates of deposit had an exact value on the date appellee refused to pay them over to appellant. He has been wrongfully deprived of the use of these funds since November 13, 1973." We note that in this case the unpaid loans and the theft had an exact value on the date Fireman's refused to pay under the Bank's policy, and that Fireman's has had the use of what is essentially the Bank' s money since that time. Nor does the fact that the Bank may have alternative sources of recovery -- i.e., the assets of C.A.T.V.'s shareholders - - mean that the amount was not capable of determination. As the court expressly noted in Lovell, it does not matter that the claim is not "liquidated"; in other words, it is irrelevant to the recovery of prejudgment interest that tho amount is disputed. We consider that the proof of loss statement and the Bank's books and records provide a method of determining the damages. Therefore, prejudgment interest should have been awarded.

Id. at 503-504.

In the present case, both the time of the accrual and amount are capable of exact determination. The amount awarded $298,118.07 - could be exactly calculated by adding the amount of the medical bills paid - by Cooper

Tire, an amount undisputed by defendants. The time of accrual is the date of the execution of the written settlement agreement, or when the breach occurred October 17, 1990. The amount of interest is calculated on a six percent interest rate. Ark. Constitution, Art. 19 §13; Killam v. Texas Oil & Gas Corp., 303 Ark. 547, 798 S.W.2d 419 (1990).

Therefore, the Court finds that prejudgment interest should be awarded from October 17, 1990, through October 1, 1993, the date of entry of final judgment herein, or $53,661.25.

Based upon the foregoing, the Court hereby denies the Motion for New Trial, denies the request for attorneys' fees, and grant the Motion for Prejudgment Interest. An Amended Judgment will be entered accordingly.

IT IS SO ORDERED.

JIMM LARRY HENDREN
UNITED STATES DISTRICT
JUDGE

IN THE UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF ARKANSAS
EL DORADO DIVISION

COOPER TIRE & RUBBER COMPANY PLAINTIFF

V. NO. 91-1156

ST. PAUL FIRE & MARINE INSURANCE COMPANIES, ROBERT MAZA AND RICHARD C. PILLSBURY, M.D. DEFENDANTS

AMENDED JUDGMENT

In accordance with the Order entered this same date, the Court hereby vacates that part of the judgment entered on October 1, 1993 awarding attorneys' fees. The Court amends the Judgment so as to award plaintiff prejudgment interest in the amount of $53,661.25, in addition to that awarded in the Judgment.

ENTERED this 6th day of April, 1994.

JIMM LARRY HENDREN
UNITED STATES DISTRICT
JUDGE

29 USCS § 1132 (1994)
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*** THIS SECTION IS CURRENT THROUGH P.L. 103-465, APPROVED 12/8/94 ***

TITLE 29. LABOR
CHAPTER 18. EMPLOYEE RETIREMENT INCOME SECURITY PROGRAM PROTECTION OF EMPLOYEE BENEFIT RIGHTS REGULATORY PROVISIONS
Administration and Enforcement

29 USCS § 1132 (1994)

§ 1132. Civil enforcement

(a) Persons empowered to bring a civil action. A civil action may be brought--

(1) by a participant or beneficiary--

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 409 [29 USCS § 1109];

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this title or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this title or the terms of the plan;

* * *

12/20/90

COOPER TIRE & RUBBER COMPANY

WELFARE BENEFITS PLAN

COOPER TIRE & RUBBER COMPANY
WELFARE BENEFITS PLAN

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Article I
Establishment

Section 1.1 Welfare Benefits. Cooper Tire & Rubber Company (the "Company") is concerned for the security and welfare of its employees, retired employees, and their dependents. The Company has maintained certain employee benefit programs which provide for life, sickness, medical, accident, disability, and other similar benefits (the "Benefit Programs"). The Company hereby establishes the Cooper Tire & Rubber Company Welfare Benefits Plan (the "Plan").

Section 1.2 Purpose. The purpose of this Plan is to facilitate administration of the Benefit Programs designated by the Company from time to time for inclusion in the Plan. The Benefit Programs, administered through the Plan are intended to constitute a single plan for purposes of ERISA.

Section 1.3 Effective Date. The provisions of the Plan as contained herein shall be effective as of December 31, 1990. The Plan is intended to constitute a welfare benefit plan under ERISA.

Article II
Definitions

Section 2.1 Definitions. The following words and phrases shall have the meaning and application set forth below:

"Benefit Programs", means any schedule of benefits providing life, sickness, accident, medical, disability or other similar benefits that the Company from time to time shall designate for inclusion under the Plan. Such schedules are corporated by reference herein.

"Code" means the Internal Revenue Code of 1986 as amended from time to time.

"Committee" means the committee appointed in accordance with Article V herein to administer the Plan. If the Company fails to appoint a Committee, the Board of Directors of Cooper Tire & Rubber Company shall be deemed to constitute to the Committee.

"Company" means Cooper Tire & Rubber Company and any Subsidiary which adopts this Plan.

"Effective Date" means December 31, 1990.

"Employee" means any employee of the Company.

"ERISA" means the Employee Retirement Income Security Act of 1974 and the rules and regulations thereunder, as amended from time to time.

"Participant" means a person who qualifies for benefits under a Benefit Program, and participates under Article III.

"Plan" means the Cooper Tire & Rubber Company Welfare Benefits Plan, and any other Benefit Programs that the Company may specify for inclusion under the Plan.

"Plan Year" means the Plan's accounting year ending on December 31 of each year.

"Subsidiary" means any corporation in which the Company owns 50 percent or more of the combined voting power of all classes of stock entitled to vote or at least 50 percent of the total value of all classes of stock of such corporation.

"Trust" means the Cooper Tire & Rubber Company Voluntary Employees' Beneficiary Trust.

"Trustee" means the person or entity named as trustee under the Trust including any successor Trustee.

Section 2.2 Construction.

(a) This Plan shall be interpreted, construed, enforced, and administered in accordance with the laws of the United states and the State of Ohio to the extent not preempted by ERISA or other Federal laws,

(b) The titles and headings of the Plan are for convenience and reference only, shall not be

considered part of the Plan, and shall not be employed in construction of the Plan,

(c) Whenever words are used in the Plan in singular form they shall, where appropriate, be construed to include the plural.

(d) Masculine gender shall include the feminine and neuter unless the context indicates otherwise.

(e) If a provision of the Plan shall be held illegal or invalid, the illegality or invalidity shall not affect the remaining parts of the Plan, and the Plan shall be construed or enforced as if the illegal or invalid provisions had never been included in the Plan.

Article III
Participation

Section 3.1 Initial Participation

Each person who is a participant or eligible dependent in a Benefit Program designated for inclusion in the Plan shall become Participants of the Plan upon the date specified in the Schedule of Benefit Programs made a part of this Plan.

Section 3.2 Cessation of Participation. A Participant will cease to be a Participant as of the earlier of (a) the date on which the Plan terminates or (b) the date on which he ceases to be eligible to participate under Section 3.1, or (c) the date on which the applicable Benefit Program(s) terminate.

Section 3.3 Reinstatement of Former Participant. A former Participant will become a Participant again at the time he meets the eligibility requirements of Section 3.1.

Article IV
Benefits and Beneficiaries

Section 4.1 Plan Benefits. The Company shall designate, from time to time, the Benefit Programs which are to be included under the Plan. Except as provided in Section 4.3, the benefits provided under such Benefit Programs shall constitute benefits under the Plan.

Section 4.2 Permissible Benefits. The benefits designated for inclusion in the Plan may include life, sickness, accident, medical, disability, vacation, recreational or other benefits which safeguard or improve the health of an individual or protect against an interruption of a Participant's earning power.

Section 4.3 Prohibited Benefits. The Company shall not designate as benefits under the Plan workers' compensation benefits required by statute, death benefits under an insurance contract providing a cash surrender value to the Participant, pension, savings, profit sharing or stock bonus benefits, or any deferred compensation that becomes payable by passage of time, rather than as the result of an unanticipated event.

Section 4.4 Beneficiaries. In addition to providing benefits for a Participant, the Benefit Programs administered under the Plan may also provide belief its to the Participant's spouse, any child of the Participant or the Participant's spouse who is a minor or a student (within the meaning of Code Section 151(c)(4)), any other minor child residing with the Participant, and any other individual who is a person described in Code Section 152(a). Death benefits may be

provided to any beneficiary designated by a Participant under the terms of a death Benefit Program or an insurance contract forming part of the Plan.

Section 4.5 Form of Benefit. The Benefit Programs administered under the Plan may provide benefits by cash payment, a distribution of property, or the provision of services. The Benefit Programs administered under the Plan may reimburse a Participant for premiums or other payments he expends for benefits or insurance provided in the Benefit Program.

Article V
Administration of the Plan

Section 5.1 The Committee. The Board of Directors of the Company shall appoint the Committee to administer the Plan. The Committee shall consist of officers or other Employees or any other persons who shall serve at the request of the Board of Directors. Any member of the Committee may resign by delivering a written resignation to the Board of Directors and to the Committee. Vacancies on the Committee, which result from resignation, death, removal, or otherwise, shall be filled by the Board of Directors.

Section 5.2 Powers and Duties of the Committee. Except as otherwise provided in a Benefit Program designated for inclusion in the Plan and in the absence of a different allocation of power and duties pursuant to Section 5.4 below, the Committee shall have the following powers and duties;

(a) to construe and interpret the provisions of the Plan;

(b) to prescribe procedures to be followed by Participants and beneficiaries when applying for benefits;

(c) to decide all questions of eligibility for Plan participation;

(d) to conform to the requirements of ERISA;

(e) to obtain from the Company, Participants, insurance company,, and any other persons, information necessary for the proper administration of the Plan;

(f) to establish procedures pursuant to Section 5.4 for allocating and delegating fiduciary powers and duties (other than Trustee responsibilities as defined in Section 405(c)(3) of ERISA);

(g) to determine the amount, manner, and time of payment of benefits;

(h) to appoint, retain, remove, or consult with counsel, actuaries, accountants, or other persons concerning the operation of the plan;

(i) to provide the Trustee with guidelines for investment of Trust assets;

(j) to review appeals of denied claims for benefits pursuant to Section 5.5 below;

(k) to do other acts reasonably necessary to administer the Plan in accordance with its terms or as may be provided for or required by law; and

(l) to adopt those rules and regulations it deems necessary or desirable for the conduct of its affairs;

(m) to notify the insurance company in writing of the termination of the Plan.

Section 5.3 Procedures.

(a) Voting. A majority of the members of the Committee shall constitute a quorum for the transaction of business. All actions taken by the Committee shall be by majority vote of the members present at the meeting, except for those matters which have been allocated or delegated pursuant to Section 5.4 below to a particular person.

(b) Plan Administrator, Chairman and Secretary. The Committee, by a majority vote of its members, shall appoint a Plan Administrator, Chairman and Secretary. The Plan Administrator, as appointed by the Committee, shall be the "Named Fiduciary" of the Plan with respect to administrative matters.

Section 5.4 Allocation and Delectation of Fiduciary Authority and Duties. The Committee may agree in writing to allocate among the members of the Committee the various powers and duties stated in Section 5.2 other than the responsibility to decide appeals of benefit claims.

Section 5.5 Claims Procedure. With respect to each benefit claim, the Committee shall follow the claims procedure set forth in the Benefit Program for which such claim was submitted.

Section 5.6 Records and Reports.

(a) The Committee shall be entitled to rely upon certificates, reports and opinions provided by any accountant or legal counsel employed by the Company or the Committee. The Committee shall keep a record of all of its proceedings and acts, and shall keep all such books of account, records, and other data as may be necessary for the proper administration of the Plan.

(b) Each Participant and each Participant's designated beneficiary must file with the Committee, from time to time, in writing, his post office address and each change of post office address of such Participant or beneficiary. Any communication, statement or notice addressed to a Participant or beneficiary at the last post office address filed with the Committee, or if no address is filed with the Committee, the last post office address as shown on the Company's records, will be binding on the Participant and his beneficiary for all purposes of the Plan. Neither the Committee nor the Trustee shall be required to search for or locate a Participant or a beneficiary.

Section 5.7 Remuneration. Unless otherwise determined by the Company, the members of the Committee shall serve without compensation for services to the Plan; however, all expenses of the Committee shall be paid by the

Company. Such expenses shall include any expenses incidental to the functioning of the committee, including but not limited to fees of accountants, legal counsel and other specialists, or any other costs of administration of the Plan.

Section 5.8 Liability and Indemnification.

(a) A member of the committee shall not be liable for any act, or failure to act, of any other member of the Committee, except to the extent that such member:

(1) knowingly participates in, or undertakes to conceal, an act or omission of another Committee member, knowing that such act or omission is a breach of fiduciary duty to the Plan;

(2) fails to comply with the specific responsibilities given a person as a member of the Committee, and such failure enabled another member of the Committee to commit a breach of fiduciary duty to the Plan; or

(3) has knowledge of a breach of a fiduciary duty to the Plan by another member of the Committee, unless such member makes reasonable effort under the circumstances to remedy such breach.

(b) Each member of the Committee shall be liable with respect to his own act of willful misconduct.or gross negligence concerning the Plan. The Company shall indemnify the Committee and/or each of its members for part or all of any expenses, costs, or liabilities arising out of the performance of duties required by the terms of the Plan or Trust, except for those expenses, costs, or liabilities arising out of a member's willful misconduct or gross negligence.

Section 5.9 Reliance on Statements. The Committee, in any of its dealings with Participants hereunder, may conclusively rely on any written statement, representation, or documents made or provided by such Participants.

Section 5.10 Wire Transfers. As directed by the Company or the Committee, the Trustee shall wire transfer funds (to the extent the Trust is adequately funded) to any person or entity for the payment of claims and charges for services.

Article VI
Amendment or Termination

Section 6.1 Amendment. The Company expressly reserves the right at any time to amend the Plan, by resolution of the Board.of Directors, to the extent permitted under the Code and ERISA.

Section 6.2 Termination. The Company intends to continue the Plan indefinitely. However, the Company reserves the right to terminate the Plan at any time.

Article VII
Miscellaneous Provisions

Section 7.1 Information to be Furnished. Participants shall provide the Company and the Committee with such information and evidence, and shall sign such documents, as may reasonably be requested from time to time for the purpose of administration of the Plan.

Section 7.2 Limitation of Rights. Neither the establishment of the Plan nor any amendments hereof, nor the payment of any benefits, will be construed as giving to any Participant or other person any legal or equitable right against the Company or the Committee, except as provided herein.

Section 7.3. Nondiscrimination. The Plan shall satisfy the nondiscrimination requirements contained in Article IX of the Trust.

IN WITNESS WHEREOF, the Company has executed the Plan on this _____ day of December, 1990.

COOPER TIRE & RUBBER
COMPANY, ("The Company")

By_____
Its_____
and
By_____
Its_____

Date_____

COOPER TIRE & RUBBER COMPANY
WELFARE BENEFITS PLAN
SCHEDULE OF BENEFIT PROGRAMS,
as of December 31. 1990

Pursuant to the provisions under Section 4.1 of the Cooper Tire & Rubber Company Welfare Benefits Plan (the Plan), the following Benefit Programs are hereby included under the Plan:

Program Number	Name of Program
519	Cooper Tire & Rubber Company Salaried Employees Health Care Plan
520	Cooper Tire & Rubber Company Hourly Employees Health Care Plan-Findlay
521	Cooper Tire & Rubber Company Hourly Employees Health Care Plan-Texarkana
522	Cooper Tire & Rubber Company Hourly Employees Health Care Plan-Clarksdale
523	Cooper Tire & Rubber Company Hourly Employees Health Care Plan-Auburn
524	Cooper Tire & Rubber Company Hourly Employees Health Care Plan-El Dorado
533	Cooper Tire & Rubber Company Hourly Employees Health Care Plan-Bowling Green

IN WITNESS WHEREOF, the Company has executed this Schedule on this _____ day of December, 1990.

COOPER TIRE & RUBBER
COMPANY, ("The Company")

By_____
Its_____
and
By_____
Its_____

Date_____

COOPER TIRE & RUBBER COMPANY
FINDLAY, OHIO

SALARIED EMPLOYEES HEALTH CARE PLAN

Effective January 1, 1983, for full time salaried employees, the Company Group Hospitalization and Surgical Benefits, except in cases covered by a Worker's Compensation Act, will be as hereinafter stated:

* * *

(e) Subrogation

In the event an Employee or dependent of an Employee, including the surviving spouse or a surviving dependent of a deceased Employee, is legally entitled to recover, including recovery under uninsured motorist coverage, all or a portion of the cost of a service or prescription drug covered by this Plan from a third party, the Company will upon making payment under this Plan succeed to any rights of recovery the Employee or dependent may have or acquire (with respect to such service or prescription drug) against any person or organization except insurers of individual hospital, surgical, or medical policies issued to the Employee or dependent.

Employees (including dependents, surviving spouses or surviving dependents of deceased Employees) by acceptance of such benefit payments agree to furnish such information and assistance, and execute such assignment and other instruments as the Company may reasonably request to facilitate enforcement of the successor rights of the Company. Employees and their dependents shall take no action prejudicing such rights of the Company.

TO: All Salaried Employees

FROM: C. F. Stumpp

SUBJECT: Salaried Employee Benefits Handbook

Attached is a complete set of new pages for your Benefits Handbook. Please remove ali of the old pages and insert these new pages behind the appropriate tabs.

There have been many changes in law requiring different language in many sections, so we want to be sure you have received your new set of pages. Please sign the acknowledgment below and return this page to your local personnel office, or if you work in the Findlay office, to Employee Services.

Please take the time to read this material. If you have any questions contact your local personnel office or Employee Services in Findlay.

I hereby acknowledge receipt of the Handbook pages dated 1-89.

_____ _____

Signature Date

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Rights and Protections

As a Participant in the various Cooper Tire & Rubber Company Benefit Plans, you are entitled to certain rights and protections under the Employees' Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

(1) examine, without charge, at your local personnel office or Employee Services (in Findlay) all Plan documents, including insurance contracts and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.

(2) obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Administrator may make a reasonable charge for the copies.

(3) receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this annual report.

(4) if appropriate, obtain, once a year, a statement of the total benefits accrued and the nonforfeitable (vested) benefits (if any) or the earliest date on which benefits will become nonforfeitable (vested).

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of these Plans. The people who operate your Plans, called "fiduciaries", have a duty to do so prudently and in the interest of you and the other Plan Participants and beneficiaries.

No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

If your claim for a benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan Administrator review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $100 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Area Office of the U.S. Labor Management Services Administration, Department of Labor.

* * *

Claims Procedure

To receive benefits under this Plan, your survivor must file a claim for benefits with the Company. The claim must include a certified copy of the death certificate.

Should a claim for benefits be partially or totally denied, a written notice will be provided to your survivor stating:

(1) the specific reason for denial with reference to the pertinent policy provisions,

(2) a description of any material needed to complete the claim and an explanation of why such material is needed, and

(3) a notice of the survivor's right to have the denial reviewed, and an explanation of the appeal procedure.

If your survivor wishes to appeal the denial of a claim he/she should be a written request of appeal within 60 days of receipt of the original denial. As a part of the appeal the survivor or appointed representative has the right to:

(1) review all pertinent documents,

(2) submit comments in writing, and

(3) receive a written decision no sooner than 60 days but no later than 120 days after receipt of the original denial.

The written appeal decision shall contain specific reasons for denial and make specific references to the pertinent policy or plan provisions on which the decision is based.

Administration Of The Plan

The Cooper Tire & Rubber Company Salaried Employees Survivor Income Benefit Plan is sponsored and administered by Cooper Tire & Rubber Company, Lima and Western Avenues, Findlay, Ohio 45840. The Company's Employer Identification Number is 34-4297750. This plan is a welfare plan and designated as Plan No. 501 for reporting purposes. The Company, as Plan Administrator, has designated as its agent for service of legal process J. A.

Reinhardt, Lima and Western Avenues, Findlay, Ohio 45840 (tel. (419) 423-1321).

The Plan year ends on December 31 of each year. Benefits are provided through a combination of Company purchase of an insurance contract from Union Central Life Insurance Company and the general assets of the Company.

Miscellaneous

The description of the benefits given in this summary only ,highlights your benefits. For complete details regarding these benefits consult a complete copy of the Plan. In no way can this summary change, add to, or take away from provisions as set forth in the documents governing this Plan.

The Company expects this Plan to be permanent, but reserves the right to amend, modify, enlarge, or terminate it at any time.

Health Care Plan

Cooper provides an excellent Health Care Plan for all full-time salaried employees who have completed thirty (30) days of Continuous Credited Service and who are actively at work on that date. Qualified dependents also become covered at the same time. Coverage for you and your dependents will stop when you cease employment with the Company except under certain conditions as outlined in the Plan.

As of 1989, this plan is provided at no cost to the employee. However, if the cost per employee to provide this plan continues to rise, it is possible that employees will be asked to share in the cost increase. Should rising costs so require, you will be advised of any cost-sharing revision to the plan.

Health Care Benefits

There are three major parts to the Plan: Basic, Major Medical, and Prescription Drug.

Basic Plan

- Up to 730 days of hospital room and board (semiprivate rate)
- Miscellaneous in-hospital expenses
- Outpatient diagnostic lab and X-Rays ($550 yearly maximum)
- Post-hospital confinement
- Surgical fees (reasonable and customary)
- Limited dental surgery
- Limited chiropractic service

Major Medical

This portion of the Plan is designed to help compensate you for certain health care costs not paid for by the Basic Plan, such as visits to a doctor's office for illness or injury.

After a $100 deductible per family member per calendar year (no more than two deductibles per family), any

further covered expenses would be shared. The Company will pay 80%, and you will pay 20%. There is a $100,000 per year maximum for each family member, and a $400,000 lifetime maximum per family member.

Prescription Drug Program

Employees and their eligible dependents are provided prescription drug coverage under two plans. The **Prescription Delivery System** (PDS) provides for all of your covered, **non-emergency** prescription needs through a mail-order system which does not require any employee co-payment. The **Prescription Card System** (PCS) provides a method for you to secure your **emergency** prescription needs by presenting your prescription, along with your PCS Card and a $3.00 co-payment fee, to any member pharmacy.

Circumstances Which May Result In The Disqualification, Ineligibility Or Denial Of Benefits Under This Plan

(1) The employee does not correctly complete and submit for payment a claim for benefits,

(2) The employee's claim for benefits is not payable under the terms and conditions of the current Plan,

(3) Benefits for dependents will not be payable if the dependent is employed and as a condition of that employment the dependent's employer pays any part of the cost of Health Care coverage.

(4) Certain benefit payments for employees and/or dependents may have to be repaid if they are covered under the Subrogation section of this Plan, and/or

(5) The Plan is terminated (which the Company has the right to do).

Claims Procedure

How to File a Claim

(1) Fill in completely and sign your portion of the Application for Medical Benefits form, available in Employee Services or the local Personnel Office.

(2) For hospital or clinical outpatient diagnostic X-Rays, laboratory tests or emergency room treatment procedures, only the employee portion of the claim form need be completed as long as the hospital or clinical document is received and indicates the diagnosis, type of medical procedure performed, and the charges.

(3) If your claim involves confinement in the hospital, have the hospital submit its itemized bill to Cooper. Ask your doctor to complete his/her portion of the claim form and return it to us if you have been confined or have had surgery.

(4) Turn in all bills. Any that do not qualify will be returned to you. Your claim cannot be finalized until all bills have been received.

(5) Payment will be made directly to the provider of services unless we have evidence of payment having been made by you.

(6) Each employee will receive, either at the time the claim is paid or upon receipt of the check, a statement listing all claims that have been paid, all claims not payable and the reasons why they were not paid.

Review Of Claim Denial

If you, your dependent(s) or your authorized represented, wish to appeal the denial of a claim or portion of a claim, your appeal should be submitted, in writing, to:

Manager, Benefits Administration Department
Cooper Tire & Rubber Company
Lima and Western Avenue
Findlay, Ohio 45840

within sixty (60) days of receipt of the original denial. As a part of the Claim Review procedure you will have the opportunity to:

(1) review all pertinent documents,

(2) submit any additional comments or maternal necessary to perfect the claim, and

(3) receive a written decision no sooner than sixty (60) days but not later than one hundred twenty (120) days after receipt of the original denial.

The written appeal decision shall contain specific reasons for denial and make specific reference to the pertinent Plan provisions on which the decision is based.

Administration Of The Plan

The Cooper Tire & Rubber Company Salaried Employees Health Care Plan is sponsored and administered by Cooper Tire & Rubber Company, Lima and Western Avenues, Findlay, Ohio 45840. The Company's Employer Identification Number is 34-4297750. This Plan is a welfare plan and is designated as Plan No. 519 for reporting purposes. The Company, as Plan Administrator, has designated as its agent for service of legal process J. A. Reinhardt, Lima and Western Avenues, Findlay, Ohio 45840 (tel. (419) 423-1321). The benefits from this Plan are paid from the general funds of the sponsor. The Plan year ends on December 31 of each year.

Miscellaneous

The description of the benefits given in this summary only highlights your benefits. For complete details regarding these benefits consult a complete copy of the Plan. In no way can this summary change, add to, or take away from provisions as set forth in the documents governing this Plan.

The Company expects this Plan to be permanent, but reserves the right to amend, modify, enlarge, or terminate it at any time.

* * *

RECEIPT AND SUBROGATION AGREEMENT

The undersigned hereby acknowledges RECEIPT from the Cooper Tire & Rubber Company of the sum of One thousand six hundred and 00/100 Dollars ($1600.00) in full settlement of all claims and demands of the undersigned and any spouse or dependents of the undersigned for any medical costs, expenses or any other items whatsoever payable under the Cooper Tire Medical Payment Plan with regard to any accident, illness, or injury commencing on or about the 23rd day of June, 1988, or any medical treatment or services rendered during the period commencing on or about the 3rd day of October, 1988, and ending an or about the 30th day of November, 1988.

In consideration of and to the extent of said payment the undersigned hereby subrogates said Cooper Tire & Rubber Company, to all of the rights, claims and interest which the undersigned may have against any person or corporation liable for the loss mentioned above, and authorizes the said Cooper Tire & Rubber Company to sue, compromise or settle in the under-signed's name or otherwise all such claims and to execute and sign releases and acquittances and endorse checks or drafts given in settlement of such claims in the name of the undersigned, with the same force and effect as if the undersigned executed or endorsed them.

Warranted no settlement has been made by the undersigned with any person or corporation against whom a claim may lie, and no release has been given to anyone responsible for the loss, and that no such settlement will be made nor release given by the undersigned without the written consent of the said Cooper Tire & Rubber Company and the undersigned covenants and agrees to cooperate fully

(and to exert him best efforts to cause any affected spouse or dependent to cooperate fully) with said Cooper Tire & Rubber Company in the prosecution of such claims, and to procure and furnish all papers and documents necessary in such proceedings and to attend court and testify (and to exert his best efforts to cause any affected spouse or dependent to attend court and testify) if Cooper Tire & Rubber Company deems such to be necessary but it is understood the undersigned is to be saved harmless from costs in such proceedings.

This RECEIPT AND SUBROGATION AGREEMENT is subject to the provisions of Article 12, Section E of Cooper Salaried Employees Medical Benefits, effective 1/1/86.

In Witness Whereof I have hereto set my hand and my seal this _____ day of January, 1990.

_____(SEAL)

STATE OF ARKANSAS)
) ss:
COUNTY OF UNION)

On the _____ day of January, 1990 before me came Robert A. Maza, to me known to be the individual described in, and who executed, the foregoing instrument, and acknowledged that he executed the same.

My Commission Expires _____

_____
Notary Public

1995 U.S. App. LEXIS 15096 printed in FULL format.

HARRIS TRUST AND SAVINGS BANK and MARTIN D. HARTOG, as co-guardians of the Estate of SANDRA DEN HARTOG, a disabled person, and MARTIN DEN HARTOG, individually, Plaintiffs-Appellants, Cross-Appellees, v. PROVIDENT LIFE AND ACCIDENT INSURANCE COMPANY, a Delaware corporation, Defendant-Appellee, Cross-Appellant, and CAMPBELL SOUP COMPANY, a New Jersey domestic corporation, Defendant-Appellee.

HARRIS TRUST & SAV. BANK v. PROVIDENT LIFE & ACCIDENT INS. CO.

Nos. 94-2021, 94-2296

UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

1995 U.S. App. LEXIS 15096

January 6, 1995, Argued

June 19, 1995, Decided

PRIOR HISTORY: [*1] Appeal from the United States District Court for the Northern District of Illinois, Eastern Division. No. 93 C 5083. Suzanne B. Conlon, Judge.

DISPOSITION: AFFIRMED.

COUNSEL: For HARRIS TRUST AND SAVINGS BANK, MARTIN D. HARTOG, as co-guardians of the Estate of SANDRA DEN HARTOG, a disabled person, and MARTIN DEN HARTDOG, individually, Plaintiffs - Appellants (94-2021, 94-2296): William J. Harte, Vickie Voukidis Blum, Chicago, IL. Herbert Stride, STRIDE & ASSOCIATES, Chicago, IL. Joan M. Mannix, HARTE & ASSOCIATES, Chicago, IL.

For PROVIDENT LIFE AND ACCIDENT INSURANCE COMPANY, a Delaware corporation, Defendant - Appellee (94-2021, 94-2296): J. Robert Geiman, William A. Chittenden, III, Douglas J. Varga, PETERSON & ROSS, Chicago, IL.

For CAMPBELL SOUP COMPANY, a New Jersey Domestic Corporation, Defendant - Appellee (94-2021): Scott B. Greene, Jeffrey C. Clark, PHELAN, POPE, CAHILL & DEVINE, Chicago, IL.

JUDGES: Before CUMMINGS and KANNE, Circuit Judges, and GRANT, District Judge. n1

n1 The Honorable Robert A. Grant of the United States District Court for the Northern District of Indiana is sitting by designation.

OPINIONBY: ROBERT A. GRANT

OPINION: GRANT, District Judge. This action involves a dispute over insurance coverage provided under an employee welfare benefits plan governed by the Employee Retirement Securities Act ("ERISA"). Harris Trust and Savings Bank

and Martin Den Hartog, co-guardians of the estate of Mr. Den Hartog's disabled daughter Sandra, brought suit against Campbell Soup Company and Provident Life and Accident, the administrator of Campbell's Group Benefits Plan, seeking a declaration of Sandra's rights under the Plan, specifically her right to continued coverage. Campbell filed a counterclaim under *29 U.S.C. § 1132(a)(3)* seeking restitution of benefits it had advanced on Sandra's behalf under the Plan's third party exclusion provision. Cross-motions for summary judgment were filed; the defendants ultimately prevailed; [*2] and plaintiffs were ordered to pay $ 290,241.53 in restitution. See *Harris Trust & Savings v. Provident Life and Acc. Ins. Co., 854 F. Supp. 524 (N.D. Ill. 1994)*. The district court, however, denied Provident's motion for attorneys' fees and costs under *29 U.S.C. § 1132(g)(1)*. This appeal and cross-appeal followed. For the following reasons, we now AFFIRM.

I. BACKGROUND

Sandra Den Hartog was rendered a quadriplegic when an automobile in which she was riding was struck by a train in September 1985. At the time of the accident, Sandra's medical insurance coverage was provided by her father's employer, Specialty Brands, Incorporated. Pursuant to the Specialty Brands' Employee Benefits Plan, all medical expenses relating to the accident were paid by the plan's administrator, Lincoln National Life Insurance Company, subject to a "Third Party Limitation" provision, which provided as follows:

If an individual insured under the policy has . . . medical or dental charges . . . as a result of the negligence or

intentional act of a third party, and makes a claim to Lincoln National for benefits under the policy for such charges, the insured individual (or legal representative of a minor [*3] or incompetent) must agree in writing to repay Lincoln National from any amount of money received by the insured individual from the third party, or its insurer. The repayment will be to the extent of the benefits paid by Lincoln National, but will not exceed the amount of the payment received by the individual from the third party, or its insurer. . . .

On March 4, 1986, Martin Den Hartog filed a personal injury lawsuit on his daughter's behalf against Conrail, the owner and operator of the train, and Peter Beck, the engineer. Consistent with the third party limitation provision, Mr. Den Hartog executed written agreements to repay Lincoln National the money it had advanced for Sandra's medical expenses under the Specialty Brands' Plan. The lawsuit was settled on January 26, 1989 for $ 7 million. n2 As part of the settlement, Sandra's estate reimbursed Lincoln National for the benefits it had advanced on Sandra's behalf, in an amount exceeding $ 400,000.00.

n2 The settlement generates sufficient annual income to cover Sandra's medical expenses.

[*4]

On March 31, 1988, while the lawsuit was still pending, Specialty Brands sold its Thornton Illinois plant to Campbell Soup Company. Mr. Den Hartog consequently became a Campbell employee and a participant in Campbell's Soup Company Group Benefit Plan ("the Plan" or "the Campbell Plan") which was fully funded by Campbell and administered

by Provident Life and Accident Insurance Company. Although employees were not furnished with a written summary of the Campbell Plan's provisions until June 1989, they were assured at the time the transition occurred that their insurance benefits would remain the same and were instructed to rely on the terms of the Specialty Brands Plan in determining the extent of their coverage under the new Campbell Plan.

Although Sandra became eligible for coverage under the Campbell Plan on March 31, 1988, her eligibility was subject to a pre-existing condition clause, which provided:

In the event you or an eligible dependent is totally disabled on the date your benefits with respect to your eligible dependent becomes effective, no benefits will be payable under this Plan for expenses incurred for treatment of the condition causing the total disability [*5] until . . . the date a person has been covered under this Plan for a period of 12 consecutive months.

The Specialty Brands' Plan, however, contained an "Extension of Benefits" provision, which provided:

If an individual's insurance terminates because of termination of the policy and while the individual is totally disabled, the Medical Insurance hereunder will be extended with respect to the illness causing the individual to be totally disabled as of the date of termination of the policy. Such benefits will be extended while the insured remains so disabled until the earlier of: (a) twelve consecutive months beyond the date the individual's insurance terminates, or (b) the date the individual becomes eligible for coverage under another plan

of group insurance provided such plan does not contain a pre-existing conditions limitation applicable to such individual.

Consistent with that provision, Lincoln National continued to pay Sandra's medical expenses from March 31, 1988 to March 31, 1989. When Sandra's coverage under the Specialty Brands' Plan lapsed, Provident began paying her accident-related medical expenses, and continued to do so from April 1, 1989 to June [*6] 15, 1991.

In June 1989, Campbell published a new Summary Plan Description which described the conditions, limitations, exclusions, and eligibility requirements for receipt of medical benefits under its employee benefits plan. The provisions were virtually identical to those of the Specialty Brands' Plan and, like its predecessor, included a limitation of liability for injuries or illnesses caused by third parties. The Plan specifically provided that:

ACTS OF THIRD PARTIES

Medical care benefits are not payable to or for a person covered under this Plan when the Injury or Illness to the covered person occurs through the act or omission of another person. However, the Provident may elect to advance payment for medical care expenses incurred for an Injury or Illness in which a third party may be liable. For this to happen, the covered person must sign an agreement with the Provident to pay the Provident in full any sums advanced to cover such medical expenses from the judgment or settlement he or she receives.

In July 1989, Provident sent Mr. Ben Hartog two repayment acknowledgement forms seeking information about the personal injury lawsuit and asserting a right to subrogation. [*7] Mr. Ben Hartog never signed or returned the forms.

After its initial inquiries were ignored, Provident began to investigate the status of Sandra's lawsuit against Conrail. In October or November 1990, it learned that the case had been settled. When Provident's repeated efforts to obtain reimbursement for benefits it had paid on Sandra's behalf were unsuccessful, Campbell exercised its discretion under the third party exclusion and directed Provident to cease payment of all accident-related claims effective June 15, 1991. The present litigation ensued.

The parties filed cross-motions for summary judgment in the district court, each contending that there were no genuine issues of material fact which would preclude the entry of judgment in their favor. While the plaintiffs and Campbell argued over whether coverage was excluded under the Acts of Third Parties provision and whether the provision required reimbursement, Provident contended that it should not have been a party to the litigation in the first place, because it was not a fiduciary within the meaning of ERISA. The district court agreed with Provident and granted its motion for summary judgment. It also agreed with Campbell's [*8] interpretation of the Acts of Third Parties provision, holding that the provision not only precluded coverage for Sandra's pre-existing condition, but required repayment of all benefits which Campbell and Provident had advanced on Sandra's behalf. The court accordingly granted Campbell's motion for summary judgment and denied the plaintiffs' motion.

Provident thereafter sought to recover attorneys' fees and costs as a prevailing party under *29 U.S.C. § 1132(g)(1).* Its motion was denied.

II. DISCUSSION

The issues presented on appeal are fairly straight forward: (1) is Provident a fiduciary within the meaning of ERISA; (2) does the third party exclusion provision apply and preclude coverage as a matter of law; (3) is Campbell entitled to restitution; and (4) is Provident entitled to attorneys' fees and costs under *29 U.S.C. § 1132(g)(1)?* We address each in turn.

A. Provident's Relationship to the Plan

ERISA defines a plan fiduciary as follows:

[A] person is a fiduciary with respect to a plan to the extent (i) he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or [*9] disposition of its assets, (ii) he renders investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or other property of such plan, or has any authority or responsibility to do so, or (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan.

29 U.S.C. § 1002(21)(A).

Plaintiffs contend that Provident has the type of discretionary authority and responsibility necessary to qualify

as a plan fiduciary, and is therefore liable for any breach of its contractual and fiduciary duties. They cite as examples, plan provisions which give Provident the right: to elect to advance benefits under the Acts of Third Parties provision; to decline payment of benefits if the medical procedures, fees and/or time involved are not itemized; to make the final determination with regard to payment for charges or services or procedures that are not clinically proven safe and effective; and to determine what constituted "satisfactory evidence" of a dependent's good health in determining eligibility.

The district court found, however, that Provident was not a "fiduciary" within the meaning of § 1002, because [*10] its duties with respect to the Campbell Plan were "ministerial and non-discretionary," *Pohl v. National Benefits Consultants, Inc., 956 F.2d 126, 129 (7th Cir. 1992); Geraldi v. Pertec Computer Corp., 761 F.2d 1323, 1325 (9th Cir. 1985); Harris v. Provident Life and Accident Ins. Co., 776 F. Supp. 1450, 1453 (D. Or. 1991),* and accordingly granted Provident's motion for summary judgment. We have reviewed that decision de novo, *Hedberg v. Indiana Bell Telephone Company, Inc., 47 F.3d 928, 931 (7th Cir. 1995); Anderson v. Baxter Healthcare Corp., 13 F.3d 1120, 1122 (7th Cir. 1994),* and find that Provident was, indeed, entitled to judgment as a matter of law.

The undisputed evidence shows that the Campbell Plan was created and fully funded by Campbell. Provident was simply hired to administer the claims process under Campbell's direction and control in accordance with an Administrative Services Agreement. Pursuant to that agreement, Campbell, not Provident, dictates the claims administration procedures

and practices which are to be followed, and all benefits eligibility determinations must be made in accordance with those procedures and practices. Campbell also retains the right under [*11] the agreement to decide all disputed and non-routine claims. Provident reports all problems in administering the program directly to Campbell, and must account to Campbell on a monthly basis for all payments that it processes.

While the plan does provide that "Provident may elect to advance benefits"under the Acts of Third Parties provision, the undisputed evidence clearlydemonstrated that Campbell, not Provident, approved the payment of Sandra'sclaims in 1989, and that Campbell ordered the discontinuation of benefitpayments in 1991. It is thus clear from the record as a whole that Provident hadno discretion in the administration of the Campbell Plan, and is not a fiduciarywithin the meaning of ERISA. See *Kyle Railways, Inc. v. Pacific Admin. Services, Inc., 990 F.2d 513, 516 (9th Cir. 1993)* (third party administrators not fiduciaries when they merely perform ministerial duties or process claims); *Pohl, 956 F.2d at 129* (plan administrator not a fiduciary where its function was clerical, mechanical, ministerial, and not discretionary); *Baker v. Big Star Division, 893 F.2d 288, 290 and n.2 (11th Cir. 1990)* ("An insurance company does not become an ERISA 'fiduciary' simply by performing [*12] administrative functions and claims processing within framework of rules established by employer."); *Blatt v. Marshall & Lassman, 812 F.2d 810, 812 (2d Cir. 1987); Howard v. Parisian, Inc., 807 F.2d 1560, 1564-65 (11th Cir. 1987); Geraldi, 761 F.2d at 1325* (insurance company hired by employer to administer ERISA plan not a fiduciary when it "performs only administrative functions, processing claims

within a framework of policies, rules and procedures established by others"); *Harris v. Provident Life and Accident Ins. Co., 776 F. Supp. at 1453* (Provident not a fiduciary of plan regulated by administrative services agreement).

B. Coverage Under the Campbell Plan

In their amended complaint, plaintiffs allege that Sandra is entitled to continued coverage under the Campbell Plan's pre-existing conditions provision, and that Campbell and Provident breached their contractual and fiduciary duties under the Plan by refusing to pay Sandra's medical expenses. To the extent the defendants assert the "Acts of Third Parties" provision as a basis for denying coverage, plaintiffs contend that the provision does not apply because it was not part of the Plan in April 1989 when Sandra became covered. [*13] They argue alternatively, that even if the provision may have been a part of the Plan in 1989, it only applies when the injury in question occurred to a "covered person", and therefore does not apply to Sandra because she was not "covered" under the Campbell Plan in 1985 when the injury occurred. Assuming that neither of those arguments prevails, the plaintiffs contend that the defendants should be estopped from denying coverage based on their prior conduct.

The district court found that the Campbell Plan has contained a third party limitation or exclusion since its inception in March 1988. When Campbell acquired the Specialty Brands plant, it assured its new employees that their insurance benefits would remain the same and advised them to rely upon the provisions of the Specialty Brands' Plan until further notice when determining their benefits. The third party limitation provision contained in the Specialty

Brands' Plan was, thus, a part of the Campbell Plan from its inception. That Mr. Den Hartog had knowledge of the limitation provision and was aware of its implications, is clearly demonstrated by the fact that he agreed to, and did in fact, repay Lincoln National Life for the [*14] benefits it had advanced on Sandra's behalf under the Specialty Brands' Plan. When Campbell ultimately issued a new Summary Plan Description in June 1989, it contained the same type of third party exclusion.

Plaintiffs' contention that the exclusion is inapplicable in the present case because Sandra was not a "covered person" when the injury occurred is equally without merit. The Plan clearly provides that: "Medical care benefits are not payable . . . when the Injury or Illness . . . occurs through the act or omission of another person." While the provision also provides that "Provident may elect to advance payment for medical care expenses . . . [for] which a third party may be liable", no participant has a right to such payments, even though he or she may be willing to agree to reimbursement. Any and all benefits payable under the Plan, including those which may have been payable for pre-existing conditions, are thus clearly subject to the third party exclusion.

Plaintiffs contend in the alternative that, even if the exclusion provision does apply, defendants should be estopped from denying coverage. They maintain that Campbell and Provident have consistently misrepresented their [*15] intention to pay Sandra's medical expenses, both verbally and by actually paying benefits for two years; that Mr. Den Hartog relied on those misrepresentations to his detriment by continuing to pay insurance premiums; and that a genuine issue of material fact, therefore, exists as to

whether defendants should be estopped from asserting any rights under the third party exclusion provision. As Campbell correctly notes, however, plaintiffs' estoppel argument was effectively raised for the first time on appeal, and is accordingly waived. *Bank Leumi Le-Israel, B.M. v. Lee, 928 F.2d 232, 235 (7th Cir. 1991); Manor Healthcare Corp. v. Guzzo, 894 F.2d 919, 922 (7th Cir. 1990).*

C. Campbell's Restitution Claim

Campbell sought to recover the amounts which had been advanced on Sandra's behalf on two theories. In Count I of its counterclaim, Campbell sought equitable relief in the form of restitution to enforce the third party exclusion and its reimbursement provision under *29 U.S.C. § 1132(a)(3).* Alternatively, Count II purported to state an independent cause of action under the federal common law of unjust enrichment which was recognized in *Provident Life & Accident Ins. Co. v. Waller, 906 [*16] F.2d 985 (4th Cir.)*, cert. denied, *498 U.S. 982, 112 L. Ed. 2d 524, 111 S. Ct. 512 (1990).* The district court appears to have proceeded under the second theory, holding that "although ERISA did not provide a cause of action for an insurer to recover advances, reimbursement was necessary to prevent unjust enrichment." n3 *Harris Trust & Savings v. Provident Life and Acc. Ins. Co., 854 F. Supp. 524, 533 (N.D. Ill. 1994).* We need not decide which of the two theories is applicable in the present case, however, for they are interrelated and Campbell would prevail under either.

n3 The district court cited Waller for the proposition that ERISA did not provide a cause of action for an insurer to recover advances. In Waller,

> however, Provident did not allege a right to restitution under *29 U.S.C. § 1132(a)(3),* rather its claim was premised on § 1132(a)(1)(B), which provides: "[a] civil action may be brought . . . by a participant or beneficiary . . . to recover benefits due him under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan". Since Provident, the plan administrator, was not a plan participant or beneficiary within the meaning of the statute, the court held that it could not bring suit under § 1132(a)(1)(B). It premised jurisdiction instead upon the federal common law of unjust enrichment. The Fourth Circuit noted, however, that: "It is probable . . . that Provident could have sued as a plan administrator under § 1132(a)(3)," *Waller, 906 F.2d at n.5.*

[*17]

29 U.S.C. § 1132(a)(3) expressly provides that: A civil action may be brought--

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan.

Campbell has clearly stated a viable claim for relief under § 1132(a)(3)(B). It is a fiduciary within the meaning of ERISA; the Plan specifically provides for repayment of benefits advanced under the third party exclusion; Campbell's

action was initiated to enforce the repayment provision; and Campbell sought "appropriate equitable relief" in the form of restitution. See *Mertens v. Hewitt Assoc., U.S. , 124 L. Ed. 2d 161, 113 S. Ct. 2063, 2069 (1993)* ("appropriate equitable relief" under § 1132(a)(3) includes "categories of relief that were typically available in equity (such as injunction, mandamus, and restitution, but not compensatory damages)"); *Health Cost Controls v. Skinner, 44 F.3d 535, 538 n.4, 5, and 7 (7th Cir. 1995)* ("although [plan administrator] clearly cannot recover compensatory [*18] damages under [§ 1132(a)(3)], if it successfully makes out a claim for restitution . . . it may be entitled to monetary relief"); *UIU Severance Pay Trust Fund v. Local Union No. 18-U, 998 F.2d 509, 512-13 (7th Cir. 1993)* (ERISA permits claim for restitution).

Restitution is available, however, "only when one party has been enriched at another's expense." *Skinner, 44 F.3d at 538 n.7.* To establish entitlement to the relief it seeks, Campbell must, therefore, demonstrate that:

(1) [it] had a reasonable expectation of payment, (2) the [plaintiffs] should reasonably have expected to pay, or (3) society's reasonable expectations of person and property would be defeated by nonpayment. C. Kaufman, Corbin on Contracts § 19A, at 50 (Supp. 1989).

Waller, 906 F.2d at 933-34. It has met that burden in the present case. The undisputed evidence clearly demonstrates that Campbell advanced benefits under the third party exclusion provision with the expectation of being repaid; that the plaintiffs knew that the Campbell Plan contained a third party limitation when they requested and received benefits on

Sandra's behalf; and that "the interests of society, as reflected in the [*19] goals of ERISA and efficient plan administration, would be served by allowance of an equitable remedy." *Waller, 906 F.2d at 993-94.*

To the extent plaintiffs contend that Campbell waived any right it may have had to restitution by failing to procure a written agreement to repay, their argument is similarly without merit.

As the district court correctly noted:

The third-party provision is a coverage limitation; it does not purport to place duties upon Provident or Campbell . . . The plan administrators simply may "elect" to advance payments in appropriate situations. Campbell did not have a contractual duty to procure a signed reimbursement agreement before paying advances. Thus, the failure to procure Martin Den Hartog's signature on the reimbursement forms was not a waiver of Campbell's legal rights under the agreement.

Plaintiffs' reliance on *Health Cost Controls v. Wardlow, 825 F. Supp. 152 (W.D. Ky. 1993),* as contrary authority, is misplaced. The district court in Wardlow held that:

Fundamental to a decision granting restitution is a determination that the defendant has obtained benefits by improper means . . . Defendant Wardow engaged in no unjust conduct. [*20] She did not obtain her medical benefits by deceit. She simply requested payment from [Health Cost Controls (HCC)] and received it. Quite unlike the beneficiary in Waller, Defendant Wardlow had no knowledge of HCC's asserted right to reimbursement when

she received her medical benefits. When HCC finally mounted its belated attempt to recover its payments, Defendant Wardlow acted legally and reasonably by refusing to make such reimbursement in the absence of a contractual requirement that she do so. (Emphasis added).

Wardlow, 825 F. Supp. at 157-58. Knowledge of the insurer's right to reimbursement was a key factor in determining whether restitution was appropriate in both Wardlow and Waller. Absent that knowledge, the beneficiary could not "reasonably have expected to pay" the insurer for benefits he or she received, and the insurer could not reasonably have expected payment. Unlike the beneficiary in Wardlow, however, Mr. Den Hartog had knowledge of the third party exclusion and Campbell's right to reimbursement when he requested and received benefits on Sandra's behalf. While Campbell's liberal policy of advancing benefits without first procuring a written repayment agreement [*21] lends itself to litigation, its right to restitution in the present case is not dependent upon the execution of a written agreement. See *Waller, 906 F.2d at 993-94.*

D. Provident's Motion for Attorneys' Fees

In its cross-appeal, Provident challenges the district court's denial of its motion to recover attorneys' fees and costs under the fee-shifting provision of *29 U.S.C. § 1132(g)(1).* Provident contends that plaintiffs' claims have no basis in fact or in law; that the law recognizes a presumption in favor of awarding fees to the prevailing party under such circumstances; and that the district court abused its discretion by refusing to award fees.

29 U.S.C. § 1132(g)(1) provides that: "In any action under this subchapter . . . by a participant, beneficiary, or fiduciary, the court in its discretion may allow a reasonable attorney's fee and costs of action to either party." We will reverse the district court's decision to grant or deny fees only if there has been an abuse of discretion. *Brewer v. Protexall, Inc., 50 F.3d 453, 458 (7th Cir. 1995).*

In determining whether fees are appropriate, the court may apply one of two recognized tests. The first test, applied by the district [*22] court in this case, requires a determination of whether the losing party's position was "substantially justified". n4 *Brewer, 50 F.3d at 458; Production & Maintenance Employees' Local 504 v. Roadmaster Corp., 954 F.2d 1397, 1404-05 (7th Cir. 1992); Meredith v. Navistar Int'l Transp. Corp., 935 F.2d 124, 128 (7th Cir. 1991). n5* Under that standard, a court may decline to award fees and costs if it finds that: (1) the losing party's position had a reasonable or "solid" basis in law and fact; or (2) special circumstances make an award unjust. *Roadmaster, 954 F.2d at 1404; Bittner v. Sadoff & Rudoy Indus., 728 F.2d 820, 830 (7th Cir. 1984).* The district court found both in the present case. We agree with its assessment, and find no abuse of discretion.

n4 To be "substantially justified" the losing party's position needs to be "more than merely not frivolous, but less than meritorious." *Bittner v. Sadoff & Rudoy Industries, 728 F.2d 820, 830 (7th Cir. 1984).*

n5 The second test requires consideration of the following factors:

> (1) the degree of the offending parties' culpability or bad faith; (2) the degree of the ability of the offending parties to satisfy personally an award of attorneys' fees; (3) whether or not an award of attorneys' fees would deter other persons acting under similar circumstances; (4) the amount of benefit conferred on members of the [benefits] plan as a whole; and (5) the relative merits of the parties' positions.
>
> *Nichol v. Pullman Standard, Inc., 889 F.2d 115, 121 n.9 (7th Cir. 1989).* See also *Brewer, 50 F.3d at 458; Anderson v. Flexel, Inc., 47 F.3d 243, 250 (7th Cir. 1995); Roadmaster, 954 F.2d at 1404.*

While it is true that there is a "modest presumption . . . in favor of awarding reasonable attorney's fees to the winning party", *Bittner, 728 F.2d at 830;* see also *Roadmaster, 954 F.2d at 1405,* that presumption is not irrebuttable. The positions which plaintiffs took before the district court and on appeal, while unsuccessful, were not indefensible.

Contrary to the picture which Provident paints, the line separating fiduciaries from nonfiduciaries in the ERISA context is not a bright one. *29 U.S.C. § 1002(21)(A)(iii)* provides that: "[A] person is a fiduciary with respect to a plan to the extent . . . he has any discretionary authority or discretionary responsibility in the administration of such plan." On its face, Campbell's Summary Plan Description appears to give Provident the minimal level of discretion required under the statute. n6 It was not until extensive discovery had been completed in the present case that it

became apparent that Campbell, not Provident, called all of the shots.

> n6 We cite as but one example the Acts of Third Parties provision which gives Provident, not Campbell, the right to elect to advance payments for injuries caused by a third party tortfeasor.

[*24]

The plaintiffs' position with respect to Provident's status is further bolstered by a Department of Labor regulation which states that: "a plan administrator or a trustee of a plan must, by the very nature of his position, have 'discretionary authority or discretionary responsibility in the administration' of the plan within the meaning of section [1002(21)(A)(iii)] . . . [and] will therefore be [a] fiduciary." (Emphasis added). The Fourth Circuit has held, or at least implied, under analogous circumstances that plan administrators such as Provident are thus fiduciaries as a matter of law. See *Waller, 906 F.2d at 988 n. 5* ("It is probable . . . that Provident could have sued [as a fiduciary] under § 1132(a)(3)"); *U.S. Steel Mining Co. v. District 17, United Mine Workers of America, 897 F.2d 149, 152 (4th Cir. 1990)* (plan administrator "is clearly a fiduciary"). But see *Kyle Railways, Inc. v. Pacific Admin. Services, Inc., 990 F.2d 513, 516 (9th Cir. 1993)* (third party administrators not fiduciaries when they merely perform ministerial duties or process claims); *Pohl, 956 F.2d at 129.*

To the extent Provident contends that the plaintiffs' interpretation of the Plan lacked [*25] a factual and legal basis, we must once again disagree. The district court found that the plaintiffs' interpretation of the Plan's provisions was not objectionably unreasonable given the "confusing circumstances", i.e., the fact that: (1) "the benefit plan was instituted after Sandra's accident, but before the $ 7 million settlement was entered in the suit brought against the responsible parties"; (2) "Sandra was deemed ineligible under the new plan for a year (which could have misled Martin Den Hartog into believing that Sandra ultimately would be covered)"; and (3) "after the year of ineligibility had elapsed, the plan began to pay Sandra's expenses without (initially) requesting reimbursement." The district court thus concluded that there were special circumstances which made an award of fees unjust in the present case. We quite agree, and accordingly deny Provident's request for fees and costs on appeal.

III. CONCLUSION

For the foregoing reasons, the judgment of the district court is

AFFIRMED.

1995 U.S. Dist. LEXIS 1800 printed in FULL format.

HEALTH COST CONTROLS, Plaintiff, v. NIKOLAOS MANETAS and JAMES E. RILEY, Defendants.

HEALTH COST CONTROLS v. MANETAS

No. 94 C 00419

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS,
EASTERN DIVISION

1995 U.S. Dist. LEXIS 1800

February 10, 1995, Decided

February 13, 1995, DOCKETED

COUNSEL:

For HEALTH COST CONTROLS, plaintiff: David Alan Belofsky, James John Merriman, David A. Belofsky & Associates, Chicago, IL.

For NIKOLAOS MANETAS, defendant: Andrew Lawrence Horberg, Horka & Horberg, P.C., Burnham, IL.

JUDGES: [*1] Ruben Castillo, United States District Judge

OPINIONBY: Ruben Castillo

OPINION: MEMORANDUM OPINION AND ORDER

Plaintiff Health Cost Controls (HCC) seeks monetary relief in the amount of $ 38,263.72 and reasonable attorney fees and costs in prosecuting this action against defendants, Nikolaos Manetas and James E. Riley, under "ERISA," the Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. § 1132(a)(3), (g)(1) (1988). Pursuant to Fed. R. Civ. P. 12(b)(6), Manetas moves to dismiss the count alleging breach of reimbursement obligations (Count I) and Riley moves to dismiss the counts alleging breach of lien (Count II) and tortious interference with a contract (Count IV) of plaintiff's amended complaint.

BACKGROUND

Plaintiff's well pleaded allegations, which must be accepted as true on a motion to dismiss, *Dawson v. General Motors Corp., 977 F.2d 369, 372 (7th Cir. 1992)*, allege the following. HCC, an Illinois corporation, has been authorized to prosecute all of the subrogation and reimbursement rights of The Bakery, Cracker, Pie and Yeast Wagon Drivers Union Local 734 Welfare Fund (Fund), which is an "employee [*2] welfare benefit plan" under *29 U.S.C. § 1002(1)*. The Fund contains a reimbursement provision which states:

If you or your dependents, while insured, are injured through the act or omission of another, the benefits provided under the group policy will be paid on the condition that you or your dependent (or person legally authorized to represent you, if you are incapable of doing so yourselves) agrees in writing:

1. to pay the Insurance Company for any damages collected, to the extent of the benefits provided, immediately upon collection of damages with respect to you and your dependent whether by action at law, settlement or otherwise; and

2. to provide the Insurance Company with a lien, to the extent of the benefits provided. The lien may be filed with the person whose act caused the injuries, his/her agent or a court having jurisdiction in the matter.

Riley, an attorney, at all material times represented Nikolaos Manetas, a "participant" of the Fund within the meaning of *29 U.S.C. § 1002(7).*

Manetas was injured in a work-related accident on February 17, 1989 and received benefits totalling $ [*3] 38,263.72 from the Fund for medical expenses incurred as a result of this accident. During 1989, Manetas commenced a Worker's Compensation action (Cause No. 89 WC 30919) alleging that Alpha Baking Company, Inc. was responsible for the damages he sustained in the accident. In exchange for payment of Manetas's medical bills, Manetas executed an indemnification agreement on September 19, 1990 which obligated Manetas to reimburse the Fund out of any settlement he received and stated in relevant part:

It is hereby understood and agreed that in consideration of payment to me by BANKERS LIFE AND CASUALTY COMPANY ("BANKERS") of benefits under Policy No. 962, Certificate No. 360-30-5538 for accident or illness occurring on or about 2/89 that I, my heirs, executors and assigns:

. . .

3. Hereby assign to BANKERS all right, title and interest in and to any fund in the hands of my employer, or my employer's Workers' Compensation Carrier or State Fund, payable in release or discharge of any liability, proven or alleged, to me under any Workers' Compensation or Occupational Disease law, to the extent allowed by law.

4. Further agree to reimburse BANKERS for any and all benefits paid to [*4] me or my assignees under the above policy number and certificate number in the event that I receive any monies whatsoever from my employer or paid by any Workers' Compensation Carrier on behalf of my employer, in satisfaction or compromise of any claim made directly or indirectly pursuant to any Workers' Compensation or Occupational Disease law.

On April 2, 1993, Manetas settled his Worker's Compensation claims for $ 205,000 and has refused to reimburse the Fund because of Riley's inducements.

Prior to settlement, on December 5, 1990, HCC sent a Notice of Lien to Riley providing Riley actual notice of the Fund's right to reimbursement and its claim for a lien against the settlement which came within the possession and control of Riley who turned over all or some of such proceeds to Manetas without regard to the Fund's and HCC's lien and reimbursement rights.

On March 22, 1993, Manetas and HCC, acting through their respective attorneys, agreed to settle HCC's claims against the settlement in the Worker's Compensation

proceeding for $ 32,500. HCC has made repeated demands upon Manetas and Riley to honor this agreement but both have refused.

DISCUSSION

A motion to dismiss tests [*5] the sufficiency of the complaint, not the merits of the suit. *Triad Assoc.s, Inc. v. Chicago Housing Auth., 892 F.2d 583, 586 (7th Cir. 1989),* cert. denied, *498 U.S. 845, 112 L. Ed. 2d 97, 111 S. Ct. 129 (1990).* The court must accept all well-pleaded facts as true, draw all reasonable inferences in favor of the plaintiff, and resolve all ambiguities in favor of the plaintiff. *Dawson, 977 F.2d at 372.* The federal notice pleading system does not favor dismissal for failure to state a claim. *Gray v. County of Dane, 854 F.2d 179, 182 (7th Cir. 1988).* Thus, the question for the court is whether relief is possible under any set of facts that could be established consistent with the allegations. *Bartholet v. Reishauer A.G., 953 F.2d 1073, 1078 (7th Cir. 1992),* citing *Conley v. Gibson, 355 U.S. 41, 45-46, 2 L. Ed. 2d 80, 78 S. Ct. 99 (1957).*

HCC has brought this suit as a fiduciary n1 seeking equitable relief n2 under *29 U.S.C. § 1132* [*6] (a). ERISA permits fiduciaries to bring suit to "obtain . . . appropriate equitable relief . . . to enforce any provisions . . . of the terms of the plan." *29 U.S.C. § 1132(a)(3)(B).* The "appropriate equitable relief" HCC seeks is restitution for breach of obligation to reimburse (Count I), restitution for breach of lien (Counts II) and restitution for tortious interference with contract (Count IV). The defendants rely primarily upon an Illinois statute, 820 ILCS 305/20, which forbids liens on workers compensation proceeds, to justify

their position. Riley also asserts that Count II must be dismissed because he has no contractual or fiduciary obligations to reimburse the Fund and that if 820 ILCS 305/20 is preempted, Count IV must be dismissed because HCC's tortious interference claim is also preempted.

n1 "A party is an ERISA fiduciary to the extent it 'exercises any discretionary authority of discretionary control respecting management' of a plan. *29 U.S.C. § 1002(21)(A)(i) (1988).* The term includes any person designated under another ERISA provision which specifies that a named fiduciary may appoint others to carry out certain fiduciary responsibilities. *29 U.S.C. § 1105(c)(1)(B).* (1988)." *Health Cost Controls v. Skinner, 1995 WL 3387, *2 n.3 (7th Cir. 1995).* HCC has sufficiently alleged a fiduciary status premised upon its authorization to administer and prosecute all claims of reimbursement and subrogation under the Fund. See Compl. P 3-4. [*7]

n2 HCC specifically asks for compensatory damages in Counts I and II. Compl. P 20.A, 26. Compensatory damages, however, are unavailable under *29 U.S.C. § 1132(a)(3)(B).* See *Health Cost Controls v. Skinner, 1995 WL 3387 at *3 n.5* ("HCC clearly cannot recover compensatory damages under section 503(a)(3), if it successfully make out a claim for restitution, admittedly an equitable action, it may be entitled to monetary relief."). Thus, HCC is limited to its claim for "appropriate equitable . . . relief," which has been incorporated into all of the Counts at issue. Compl. P 5.

A. ERISA Preemption

Preemption under ERISA is explicitly governed by three clauses referred to as the preemption, savings and deemer clauses:

Except as provided in subsection (b) of this section [the saving clause], the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b).
[*8]
29 U.S.C. § 1144(a) (the preemption clause).

Except as provided in subparagraph (B) [the deemer clause], nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

29 U.S.C. § 1144(b)(2)(A) (the saving clause).

Neither an employee benefit plan described in section 1003(a) of this title . . . nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

29 U.S.C. § 1144(b)(2)(B) (the deemer clause). The interaction of these three clauses has been summarized in *Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 95 L. Ed. 2d 39, 107 S. Ct. 1549 (1987)*, which states:

If a state law "relate[s] to ... employee benefit plan[s]," [*9] it is pre-empted. *[29 U.S.C. § 1144(a).]* The saving clause excepts from the pre-emption clause laws that "regulate insurance." *[29 U.S.C. § 1144(b)(2)(A).]* The deemer clause makes clear that a state law that "purport[s] to regulate insurance" cannot deem an employee benefit plan to be an insurance company. *[29 U.S.C. § 1144(b)(2)(B).]*

Pilot Life Ins. Co., 481 U.S. at 45.

Under the preemption clause, "[a] law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan." *Shaw v. Delta Airlines Inc., 463 U.S. 85, 96-97, 77 L. Ed. 2d 490, 103 S. Ct. 2890 (1983).* The Supreme Court has repeatedly emphasized the broad scope of the preemption clause, holding that the words "related to" are to be interpreted in their "broad sense," *Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 138, 112 L. Ed. 2d 474, 111 S. Ct. 478 (1990)* citing [*10] *Shaw, 463 U.S. at 98*, and that under a "broad common-sense meaning" the statute preempts not only state laws which specifically target benefit plans but also those which have only an indirect affect on such plans. *Ingersoll-Rand Co., 498 U.S. at 139* citing *Pilot Life Ins. Co., 481 U.S. at 47* and *Alessi v. Raybestos-Manhattan Inc., 451 U.S. 504, 525, 68 L. Ed. 2d 402, 101 S. Ct. 1895 (1981).*

Under the broad sweep of the preemption clause both state laws at issue are "related to" the Fund. Illinois law provides that no workers' compensation "payment, claim, award or decision . . . shall be . . . subject to any lien." 820 ILCS 305/21. When an ERISA plan seeks subrogation or reimbursement rights in a workers' compensation settlement payment and this statutory provision is invoked to frustrate the terms of the ERISA plan this statute is clearly "related to" that ERISA plan and is subject to the preemption clause. On the other hand, five elements [*11] must be satisfied to demonstrate intentional interference with a contract under Illinois law:

These five elements are: "(1) The existence of a valid and enforceable contract, (2) The defendant's knowledge of the existing contract, (3) Intentional and malicious inducement of the breach, (4) The subsequent breach by the third person due to defendant's wrongful conduct, and (5) Damage to the plaintiff."

Cross v. American Country Insurance Co., 875 F.2d 625, 627 (7th Cir. 1989) quoting *Zamouski v. Gerrard, 1 Ill. App. 3d 890, 275 N.E.2d 429, 433 (1971).* The contract which forms the basis of HCC's tortious interference claim is the agreement providing for reimbursement of benefits between Manetas and the Fund. Tortious interference with a contract, when based upon an agreement for reimbursement of ERISA plan payments, can materially affect the administration of the ERISA plan and falls within the broad scope of the ERISA preemption clause. A finding that the preemption clause is applicable, however, is not the final step in the preemption analysis.

The saving clause exempts from preemption those State [*12] laws which regulate insurance. This clause is to be interpreted by examining its language with a "common sense view" and with reference to "the case law interpreting the phrase 'business of insurance' under the McCarran-Ferguson Act." *Pilot Life Ins. Co., 481 U.S. at 48.* "A common-sense view of the word 'regulates' would lead to the conclusion that in order to regulate insurance, a law must not just have an impact on the insurance industry, but must be specifically directed toward that industry." *Id. at 50.* While the case law evaluating what constitutes the "business of insurance" under the McCarran-Ferguson Act utilizes three criteria: first, "whether the practice has the effect of transferring or spreading a policyholder's risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities within the insurance industry." *Id. at 48-49,* quoting *Union Labor Life Ins. Co. v. Pireno, 458 U.S. 119, 129, 73 L. Ed. 2d 647, 102 S. Ct. 3002 (1982).*

[*13]

A cause of action under Illinois law for tortious interference with a contract is not a regulation of insurance and ERISA's saving clause does not prevent its preemption. Tortious interference with a contract does not satisfy any of the saving clause criteria: this cause of action is not directed at the insurance industry; it does not affect the spreading of risk, except in the most extremely attenuated and oblique manner; and it does not form a part of the policy relationship between the insurer and the insured. Instead this claim involves a third party which is not limited in application to the insurance industry. Since HCC's state law claim for

tortious interference materially affects the administration of the ERISA plan and is not protected by ERISA's saving clause the court finds that it is preempted by ERISA. n3

> n3 Although HCC cites *Health Cost Controls v. Bode, 1994 WL 262168 (N.D. Ill. 1994)* in support of its claim, this opinion focuses primarily upon jurisdictional issues and does not discuss preemption of a state law claim for tortious interference with a contract.

[*14]

With regards to 820 ILCS 305/20, the procedural posture and circumstances of this suit do not require the court to decide whether this statute regulates insurance because of the effect of what is known as the "deemer" clause. The deemer clause prevents self-funded n4 ERISA plans from being deemed an insurance company for purposes of a state law which regulates insurance. Thus, state laws which "regulate insurance" and are preserved under the saving clause cannot be applied to self-funded ERISA plans. *FMC Corp. v. Holliday, 498 U.S. 52, 112 L. Ed. 2d 356, 111 S. Ct. 403 (1990),* explains the effect of the deemer clause: "We read the deemer clause to exempt self-funded ERISA plans from state laws that 'regulate insurance' within the meaning of the saving clause. . . . As a result, self-funded ERISA plans are exempt from state regulation insofar as that regulation 'relate[s] to' the plans." *Id. at 61.* Thus, because 820 ILCS 305/20 is related to an ERISA plan and, for purposes of a motion to dismiss, the Fund is entitled to have all reasonable

inferences drawn in its [*15] favor (i.e., that it is a self-funded ERISA plan), 820 ILCS 305/20 will be assumed to be preempted for purposes of deciding whether to dismiss Counts I and II.

> n4 In its complaint, HCC alleges that the Fund is an "employee welfare benefit plan" within the meaning of *29 U.S.C. § 1002(1)* but does not allege that it is a self-funded plan. Compl. P 4. Drawing all reasonable inferences in favor of the plaintiff, the determination of whether 820 ILCS 305/21 is preempted will assume that the Fund is self-funded. It is also noteworthy that the affidavit of Christopher Michas asserts that the Fund is a self-funded health care plan. Michas Aff. P 2.

Manetas's argument that there is no preemption of 820 ILCS 305/20 because, within the meaning of *29 U.S.C. § 1003(b)(3)*, the Fund "is maintained solely for the purpose of complying with applicable workmen's compensation laws" is without merit. Manetas acknowledges that his employer provided two different types [*16] of insurance coverage from two different carriers, and that it was Commerce & Industry which provided Manetas's employer a workers' compensation policy not the Fund. Mem. of Law in Supp. of Mot. to Dismiss, 5-6.

B. Federal Common Law of ERISA

HCC has not alleged that either of the defendants are liable as fiduciaries of an ERISA plan. n5 Instead HCC relies on *29 U.S.C. § 1132(a)* which permits "appropriate equitable

relief" to redress violations of ERISA or to enforce provisions of an ERISA plan, but which does not "authorize 'appropriate equitable relief' at large." *Mertens v. Hewitt Assoc.s, U.S. , 113 S. Ct. 2063, 2067 (1993).* Monetary relief for compensatory damages are not available under this provision. *Id. at 2068.* HCC urges this court to grant it a restitutionary remedy by recognizing, under *29 U.S.C. § 1132(a),* a federal common law cause of action for restitution, breach of lien and tortious interference with a contract. See *Consolidated Mem. by Pl. in Resp. to Mot.s to Dismiss, 12-13, 20.*

n5 Those courts which have confronted the issue of whether an attorney who represents an ERISA beneficiary is an ERISA fiduciary have generally found no fiduciary relationship but have left open the possibility that under some situations such an attorney may become a fiduciary. See, e.g., *Vest v. Gleason & Fritzshall, 832 F. Supp. 1216 (N.D. Ill. 1993); Hotel Employees and Restaurant Employees Int'l Union Welfare Fund v. Gentner, 815 F. Supp. 1354 (D. Nev. 1993).* HCC does allege that Manetas is a "participant" within the meaning of *29 U.S.C. § 1002(7).*

[*17]

"In appropriate circumstances, courts may develop a federal common law governing employee benefit plans in order to supplement the statutory scheme." *Cummings v. Briggs & Stratton Retirement Plan, 797 F.2d 383, 390 (7th*

Cir. 1986) cert. denied *479 U.S. 1008, 93 L. Ed. 2d 703, 107 S. Ct. 648* (citations omitted). See also *UIU Severance Pay Trust Fund v. Local Union No. 18-U, United Steelworkers of America, 998 F.2d 509, 512 (7th Cir. 1993)* (Explaining that the "receptiveness to federal common law notwithstanding the comprehensive character of ERISA is the product of ERISA's broad preemption provision."). But this power is restricted "to its proper use--to remedy violations of the Act." *Cummings, 797 F.2d at 391.*

There must be an element of unjust enrichment in any restitutionary common law cause of action recognized under ERISA. Health Cost Controls v. Skinner, *3 n.7 ("Restitution [is a] remedy available only when one party has been unjustly enriched at another's expense."). Noting that "several district judges in this circuit [*18] as well as other courts of appeals have concluded that ERISA permits [a restitutionary] cause of action" the Seventh Circuit has allowed a restitutionary claim under the federal common law for contributions erroneously made to an ERISA plan. *UIU Severance Pay Trust Fund, 998 F.2d at 512.* However, in a recent case where the restitutionary claim was not brought against the plan, the Seventh Circuit withheld its judgment upon the issue of whether a federal common law cause of action for unjust enrichment should be recognized. *Health Cost Controls v. Skinner, *3 n.4.*

Count I of HCC's complaint seeks restitutionary relief from Manetas for a breach of the Fund's reimbursement provision and an indemnification agreement executed pursuant to that provision. For ERISA plans to effectively enforce their provisions, a restitutionary cause of action against participants who have been unjustly enriched at the

plan's expense is necessary. Thus, this court recognizes a federal common law cause of action for restitution against an ERISA plan participant and Manetas's motion for dismissal is denied.

Count II of HCC's complaint seeks restitutionary relief from Riley [*19] for a breach of lien. In light of *Central States, Southeast and Southwest Areas Health and Welfare Fund v. State Farm Mutual Automobile Ins. Co., 17 F.3d 1081 (7th Cir. 1994)*, this court does not recognize a federal common law cause of action for restitution against an ERISA participant's attorney when that attorney is not a fiduciary within the meaning of ERISA. In Central States:

State Farm settled claims with the covered individuals and refused to pay to the [ERISA plan] the value of the [ERISA plan's] subrogation rights. . . . State Farm admitted executing settlements and releases with the covered individuals after receiving notice of the [ERISA plan's] subrogation interest, but claimed that because it was not a party to the [ERISA plan's] subrogation agreement it was not under an obligation to settle claims with the [ERISA plan].

Id. at 1082. The court found that because State Farm was not a party to the ERISA plan's agreement with the covered individuals it was not a fiduciary of the ERISA plan. Thus, it did not have a duty to recognize the ERISA plan's subrogation rights and neither injunctive relief [*20] nor a constructive trust was available to the ERISA plan. Id. at 1084. HCC has alleged no facts which merit distinguishing this suit from Central States, thus, Count II is dismissed.

Count IV of HCC's amended complaint seeks restitutionary relief from Riley for tortious interference with

a contract. Although HCC asks for restitutionary relief, HCC is actually seeking compensatory damages which are not allowable under *29 U.S.C. § 1132(a). Mertens, 124 L. Ed. 2d 161, 113 S. Ct. 2063.* Even if HCC had properly sought this court's federal question jurisdiction under 28 U.S.C. § 1331 to determine whether tortious interference with a contract should be recognized under the common law of ERISA, see, e.g., *Pople v. Cox, 1993 WL 469915 (N.D. Ill. 1993); Dugan v. Nickla, 763 F. Supp. 981 (N.D. Ill. 1991),* this court would not recognize such a claim under federal common law. Recognition of a cause of action for tortious interference of contract is not necessary for the enforcement of ERISA or the provisions [*21] of ERISA plans. ERISA plans will generally have a cause of action for the violation of ERISA or the breach of the ERISA plan. See, e.g., *Central States, 17 F.3d at 1083.* Because "courts must be conscientious to fashion federal common law only when it is 'necessary to effectuate the purposes of ERISA,'" *Singer v. Black & Decker Corp., 964 F.2d 1449 (4th Cir. 1992),* and recognition of a cause of action for tortious interference is not necessary for the enforcement of either ERISA or the provisions of ERISA plans, this court does not recognize such a cause of action. Therefore, Count IV of HCC's amended complaint is dismissed.

CONCLUSION

Defendant Manetas's motion to dismiss (Count I) is denied. Defendant Riley's motion to dismiss (Counts II and IV) is granted.

ENTER:

Ruben Castillo

United States District Judge

Dated: February 10, 1995

44 F.3d 535 printed in FULL format.

HEALTH COST CONTROLS,
Plaintiff-Appellant, v. RICHARD L.
SKINNER, ROSALIE SKINNER, individually
and as administrators
of the Estate of Sharon Skinner,
a minor, RICK A. MASON, et al.,
Defendants-Appellees.

HEALTH COST CONTROLS v. SKINNER

No. 94-1433

UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

44 F.3d 535; 1995 U.S. App. LEXIS 111;
18 E.B.C. 2830

September 13, 1994
Argued January 5, 1995, Decided

PRIOR HISTORY: [**1] Appeal from the United States District Court for the Northern District of Illinois, Eastern Division. No. 94 C 307. Milton I. Shadur, Judge.

COUNSEL: For HEALTH COST CONTROLS, Plaintiff - Appellant: David A. Belofsky, James J. Merriman, BELOFSKY & ASSOCIATES, Chicago, IL, USA.

For RICK A. MASON, RICHARD L. SKINNER, individually and as administrator of the Estate of Sharon Skinner, a minor, ROSALIE SKINNER, individually and as administrator of the Estate of Sharon Skinner, a minor, Defendants - Appellees: Thomas A. Thanas, Richard B. Orloff, Scott R. Reich, MASON, ORLOFF, REICH, TROY & THANAS, Joliet, IL, USA. For GENERAL CASUALTY INSURANCE, Defendant - Appellee: Barbara Naretto Petrungaro, SWANSON, MARTIN & BELL, Chicago, IL, USA. David J. Cahill, SWANSON, MARTIN & BELL, Wheaton, IL, USA.

JUDGES: Before LAY, * BAUER, and WOOD, JR., Circuit Judges.

* The Honorable Donald P. Lay, Circuit Judge for the United States Court of Appeals for the Eighth Circuit, sitting by designation.

OPINIONBY: LAY

OPINION: [*536] LAY, Circuit Judge. Health Cost Controls ("HCC") commenced this action under section 502(a)(3) of the Employee Retirement Income Security Act of 1974 ("ERISA"). It seeks to enforce the terms of an employee benefit plan. The district court dismissed the complaint for lack of subject matter jurisdiction. We reverse and remand for further proceedings.

BACKGROUND

Richard Skinner and his daughter, Sharon Skinner, are participants in an employee welfare benefit plan ("the Plan")

established by the Mobil Oil Corporation. H.M.O. Illinois, Inc. ("HMO Illinois") provides managed care services for some Plan participants, including the Skinners, and HCC has been authorized by HMO Illinois to prosecute all of its rights to subrogation and reimbursement under the Plan. The Plan contains a reimbursement provision requiring a participant injured by a third party to reimburse [**2] the Plan for any benefits the Plan provides for the injury if the participant ultimately recovers from the third party. The Plan may recover the cost of the benefits from the amount of any settlement or judgment the participant obtained against a third party.

Sharon Skinner was injured in an automobile accident in October 1991. HCC alleges that benefits worth $ 67,815.58 were paid to Sharon for treatment of injuries sustained in the accident. The Skinners sought recovery for Sharon's injuries from a third-party tortfeasor. In 1992, HCC sent a notice of lien to the Skinners' insurance company, General Casualty Insurance Company ("General Casualty"), and the Skinners' attorney informing them of the Plan's right to reimbursement. In January 1994, the Skinners settled with the party responsible for Sharon's injuries for $118,608.87. The Skinners failed to reimburse the Plan as required by its terms, n1 and HCC filed a seven-count complaint against the Skinners as administrators of the estate of Sharon Skinner, the Skinners individually, Rick A. Mason, their attorney, and General Casualty. n2 The district court dismissed the action sua sponte for lack of jurisdiction. HCC appeals.

n1 Appellees claim they are not required to reimburse HCC under state law and that this action is

barred by the doctrine of res judicata because a state court has already denied HCC's liens. That issue can be raised in the district court on remand; it is not properly before this Court because the district court dismissed the action solely on the ground that subject matter jurisdiction was lacking. [**3]

n2 Included in the seven counts of the complaint are state claims for breach of lien and tortious interference with contract against General Casualty and the Skinners' attorney. Those claims were joined under principles of supplemental jurisdiction.

ANALYSIS

The narrow question presented for our review is whether HCC properly invoked the subject matter jurisdiction of the district court. This Court reviews de novo a dismissal for lack of subject matter jurisdiction. Joyce v. Joyce, 975 F.2d 379, 382 (7th Cir. 1992).

Section 502(a)(3) of ERISA permits fiduciaries to bring suit "(A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan." *29 U.S.C. § 1132(a)(3) (1988).* Section 502(e) grants federal courts exclusive jurisdiction to entertain actions brought under section 502. *29 U.S.C. § 1132(e)* [**4] (Supp. 1993). HCC's complaint states that it is a fiduciary of the Plan within the meaning of section 502(a)(3) and that it seeks "to obtain appropriate equitable

and declaratory relief" to enforce provisions of the Plan under that section. n3 At the end of each count of its [*537] complaint, however, HCC requests "compensatory damages" in the amount of the benefits it provided to Sharon Skinner for her injuries. The district court found that it lacked subject matter jurisdiction over this action because the relief HCC sought was not equitable in nature, but rather was a claim for "money damages," which would be impermissible under section 502(a)(3). We reverse and remand.

n3 The district court expressed doubt that HCC was in fact a fiduciary as defined in ERISA. A party is an ERISA fiduciary to the extent it "exercises any discretionary authority or discretionary control respecting management" of a plan. *29 U.S.C. § 1002(21)(A)(i) (1988)*. The term includes any person designated under another ERISA provision which specifies that a named fiduciary may appoint others to carry out certain fiduciary responsibilities. *29 U.S.C. § 1105(c)(1)(B) (1988)*. HCC therefore may qualify as an ERISA fiduciary, although we leave the ultimate resolution of that issue to the district court. In any event, like the district court, we will assume HCC is a fiduciary in rendering this decision.

[**5]

The district court found that HCC failed to properly allege equitable relief
permitted under the statute. n4 However, we find the district court's reasoning does not negate the existence of federal subject matter jurisdiction, but rather indicates that HCC may

have failed to state a proper claim for relief under section 502(a)(3). n5

n4 HCC asserts in the alternative that its claim arises under the federal common law of ERISA. It asks this Court to imply a federal common-law remedy of unjust enrichment under ERISA. *See Provident Life & Accident Ins. Co. v. Waller, 906 F.2d 985, 993 (4th Cir.)* (implying a federal common-law remedy for unjust enrichment), cert. denied, *498 U.S. 982, 112 L. Ed. 2d 524, 111 S. Ct. 512 (1990)*. Such a federal common-law claim has been previously recognized by Judge Suzanne B. Conlon, who also sits in the Northern District of Illinois, Eastern Division. See *Pople v. Cox, No. 93 C 6274, 1994 WL 63006, at * 5 (N.D. Ill. November 9, 1993)*. In a later district court case, Judge Shadur, relying on his reasoning in this case, stated:

With all respect, that conclusion by this Court's colleague Honorable Suzanne Conlon is directly at odds with the teaching of Massachusetts Mutual that rejects such implied claims where Congress has been so careful in devising "ERISA'S interlocking, interrelated, and interdependent remedial scheme, which is in turn part of a 'comprehensive and reticulated statute' " (473 U.S. at 134).

*Hedberg v. Zaldivar, No. 94 C 1117, 1994 WL 71424, at * 2 (N.D. Ill. Mar. 2, 1994)*. We need not determine at this juncture which view is correct because the court below did not address whether HCC

had stated a proper claim for relief under federal common law. [**6]

n5 Restitution may be in the form of monetary relief. Thus, although HCC clearly cannot recover compensatory damages under section 502(a)(3), if it successfully makes out a claim for restitution, admittedly an equitable action, it may be entitled to monetary relief.

When both the subject matter jurisdiction of the federal court and the substantive claim for relief are based on a federal statute, dismissal for lack of subject matter jurisdiction is proper only when the allegations of the complaint are frivolous. *Malak v. Associated Physicians, Inc., 784 F.2d 277, 279-80 (7th Cir. 1986); Timberlane Lumber Co. v. Bank of America, 549 F.2d 597, 602 (9th Cir. 1976);* see also *Bell v. Hood, 327 U.S. 678, 682, 90 L. Ed. 939, 66 S. Ct. 773 (1945)* (finding substantial constitutional claim adequate to invoke federal subject matter jurisdiction). As Moore's Federal Practice explains:

If a federal statute upon which a claim is premised is interpreted to be inapplicable, it could be argued that the [**7] plaintiff has failed to present a federal question and thus subject matter jurisdiction is absent. However, the courts have uniformly held that in such instances the preferable practice is to assume that jurisdiction exists and proceed to determine the merits of the claim pursuant to [Rule 12(b)(6) or Rule 56].

2A James W. Moore et al., Moore's Federal Practice P 12.07[2.-1] (2d ed. 1994). Thus, if a plaintiff fails to

properly allege a claim for relief brought under a federal statute, the case should be dismissed under Federal Rule of Civil Procedure 12(b)(6), rather than Rule 12(b)(1). *Romero v. International Terminal Operating Co., 358 U.S. 354, 359, 3 L. Ed. 2d 368, 79 S. Ct. 468 (1959)* (finding the mere assertion of a substantial claim under a federal statute sufficient to permit a district court to assume jurisdiction and determine whether the statute does provide the claimed rights); *Gonzalez v. Southern Pac. Transp. Co., 773 F.2d 637, 645 (5th Cir. 1985)* (same).

[*538] This Court ordinarily may modify a dismissal for lack of jurisdiction and convert it to a dismissal on the merits if warranted. [**8] See, e.g., *Shockley v. Jones, 823 F.2d 1068, 1073 (7th Cir. 1987); White v. Elrod, 816 F.2d 1172, 1176 (7th Cir.),* cert. denied, *484 U.S. 924, 98 L. Ed. 2d 246, 108 S. Ct. 286 (1987).* Under the circumstances in this case, however, modification would be inappropriate. The district court dismissed the action sua sponte, and HCC had no opportunity to respond or to amend its complaint. n6 The Supreme Court has stated the following with respect to dismissal under Rule 12(b)(6):

Under Rule 12(b)(6), a plaintiff with an arguable claim is ordinarily accorded notice of a pending motion to dismiss for failure to state a claim and an opportunity to amend the complaint before the motion is ruled upon. These procedures alert him to the legal theory underlying the defendant's challenge, and enable him meaningfully to respond by opposing the motion to dismiss on legal grounds or by clarifying his factual allegations so as to conform with the requirements of a valid legal cause of action. This adversarial process also crystallizes the pertinent issues and facilitates

appellate review [**9] of a trial court dismissal by creating a more complete record of the case.

Neitzke v. Williams, 490 U.S. 319, 329-30, 104 L. Ed. 2d 338, 109 S. Ct. 1827 (1989); see also *Shockley, 823 F.2d at 1073* (stressing importance of notice and opportunity to be heard before 12(b)(6) dismissal). We believe basic principles of fairness and the Federal Rules of Civil Procedure require that HCC, if faced with the possible dismissal of its complaint, have the opportunity to amend its complaint to request equitable relief under both federal common law and § 502(a)(3). n7 Whether the facts and any claim that might be pled will state a claim for relief is then for the district court to pass upon under Federal Rule of Civil Procedure 12(b)(6).

n6 As HCC urges in its appellant's brief: Even if the complaint mischaracterized the relief to which plaintiff was entitled, it was at best premature to sua sponte dismiss the complaint two days after it was filed because plaintiff never had a meaningful opportunity to be heard or to amend its complaint. The district court could not at the time have properly determined with any certainty that plaintiff could prove no set of facts sufficient to state a federal claim. [**10]

n7 The Supreme Court recently found that equitable relief under section 502(a)(3) includes "categories of relief that were typically available in equity (such as injunction, mandamus, and restitution, but not compensatory damages)." *Mertens v. Hewitt*

> *Assoc., 124 L. Ed. 2d 161, 113 S. Ct. 2063, 2069 (1993)* (emphasis in original). Restitution and constructive trust are remedies available only when one party has been unjustly enriched at another's expense. Dan B. Dobbs, The Law of Remedies § 4.1 (1973); Restatement of Restitution § 1 (1937). To the extent HCC can demonstrate the parties it has sued have been unjustly enriched at its expense, it may be able to establish it is entitled to restitution or a constructive trust, permissible forms of relief under Mertens.

Thus, reserving to the district court a determination as to whether HCC has stated a claim upon which relief may be granted, we reverse the district court's dismissal for want of subject matter jurisdiction and remand for further proceedings.

GARY HEDBERG, a minor. etc., Plaintiff,
v. RAUL A. ZALDIVAR, et al., Defendants.

HEDBERG v. ZALDIVAR

No. 94 C 11 17

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS,
EASTERN DIVISION

1994 U.S. Dist. LEXIS 2505

March 2, 1994, Decided

March 4, 1994, Docketed

JUDGES: [*1] Shadur

OPINION BY: MILTON I. SHADUR

OPINION: MEMORANDUM OPINION AND ORDER

This Court's February 25, 1994 memorandum opinion and order (the "Opinion") was issued sua sponte to remand this action to the Circuit Court of Cook County, from which it had been removed by Health Cost Controls ("HCC") via a Notice of Removal ("Notice"). That remand order had been triggered by what this Court found to be a patent lack of federal jurisdiction, so that *28 U.S.C. §1447(c)*("Section

1447(c)") compelled the remand of the case to the state court.

HCC's counsel promptly filed an emergency motion to vacate (or alternatively to stay) the remand order, supporting that motion with a thoughtful legal memorandum together with the affidavit of HCC's President John Demaret ("Demaret"). Because the issues that have been posed by HCC certainly deserve attention and due consideration, this Court orally granted the motion to stay--but not to vacate--in order to allow this Court to address HCC's contentions.

To begin with, HCC disputes the earlier (January 20, 1994) memorandum opinion and order of dismissal that this Court had entered in Health Cost Controls v. Skinner, No. 94 C 307. This [*2] opinion will disregard the ad hominem attack that HCC's counsel has voiced at his current Mem. 3 n.3, n1 and it will turn briefly to comment on Skinner in light of counsel's criticisms. In that respect, HCC's counsel fails to perceive the irony of his having quoted (Mem. 7-8) from our Court of Appeals' opinion in *Lister v. Stark, 890 F.2d 941, 944 (7th Cir. 1989)*. That very quotation demonstrates why this Court properly dismissed Skinner for lack of subject matter jurisdiction: In that case HCC as plaintiff had asserted a claim that it could not bring under ERISA. Essentially, then, HCC attempted in Skinner to enter the federal court on some sort of ERISA preemption doctrine despite the fact that Congress has expressly chosen not to confer jurisdiction on the federal courts for the type of damages claim that HCC advanced there. That of course would turn preemption doctrine on its head--it would ask this Court to "reverse" the Supreme Court's teaching in *Massachusetts Mut. Life Ins. Co. v. Russell, 473 U.S. 134,*

146, 147, 87 L. Ed. 2d 96, 105 S. Ct. 3085 (1985) as quoted [*3] in Skinner, and also to gloss over (or rather to ignore entirely) the doctrine announced in such cases as *First Nat'l Life Ins. Co. v. Sunshine-Jr. Food Stores, Inc., 960 F.2d 1546, 1543 (11th Cir. 1992)* and also quoted in Skinner.

n1 In that footnote HCC's counsel states in part:

> Incredibly, the Court in Skinner did not thereafter send timely notice of its Order and Opinion to counsel for HCC, and the minute order as well as the docket entry in the case reflect a direction that the Clerk was not to send notice or copies of the order to counsel.
>
> When counsel came to court to present the emergency motion in this case, this Court explained to him that its practice whenever it believes that lawyers ought to get an earlier rather than a later notification of action taken by this Court is to direct that such notices be transmitted from chambers, instead of undergoing the delays that frequently occur in Clerk's Office transmittals because of the administrative burdens and the volume of activity there. Whenever such notices are sent by this Court's in-chambers staff, the standard directive included in the minute order is that the Clerk's Office is not to make a separate transmittal (for the obvious reason of avoiding any needless double notification and expense). Thus HCC's counsel's implication of some sinister motivation is totally uncalled-for. In this instance this Court's law clerk who was responsible for handling the transmittal of the January 20 opinion remembered

> the Skinner case particularly, because it had been the subject of the clerk's discussion with this Court as to whether it ought to be submitted for publication. Although the law clerk's distinct recollection was that he had in fact mailed a copy of the January 20 opinion to counsel, mistakes are always possible--and this Court of course accepts the representation of HCC's lawyer that he did not receive the order until it was too late to file a timely Fed. R. Civ. P. ("Rule") 59(e) motion. All the same, counsel would be well advised to avoid the use of such pejorative terms as "incredibly" until he is aware of all of the facts--facts that this Court had the opportunity to explain only when counsel appeared on the emergency motion.

[*4]

In that respect HCC tries to have it both ways. It (or more accurately its assignor, an employee benefit plan) has an express contract that requires reimbursement, and HCC is certainly entitled to claim damages for breach of that contract. But when it is confronted with the fact that Congress has chosen not to grant fiduciaries the right to bring any ERISA-based claim of that nature, HCC essays to convert that action at law into one that it labels as equitable. This Court did not and does not now accept that chameleon-like effort. n2 In sum, there is no reason to revisit Skinner as such.

> *n2 Pople v. Cox, 1993 U.S. Dist. LEXIS 16105,* No. 93 C 6274, slip op. at 8-9 (N.D. Ill. Nov. 9, 1993) reaches the same conclusion as this Court as to

> the scope of ERISA § 1132(a)(3). Pople goes on, however, to find the existence of federal-question jurisdiction over a non-equitable claim by a fiduciary under what it characterizes as "federal common law." With all respect, that conclusion by this Court's colleague Honorable Suzanne Conlon is directly at odds with the teaching of Massachusetts Mutual that rejects such implied claims where Congress has been so careful in devising "ERISA's interlocking, interrelated, and interdependent remedial scheme, which is in turn part of a 'comprehensive and reticulated statute'" (*473 U.S. at 134).*

[*5]

To turn now to the present case, HCC urges that it should not be controlled by Skinner because the context in which this case arises is different--here HCC is not itself attempting to invoke ERISA as a plaintiff, but is rather responding to a personal injury plaintiff's effort in the state court to negate HCC's (or more accurately its assignor's) subrogation right against the settlement proceeds in the underlying lawsuit. HCC's counsel puts it this way at Mem. 7:

Rather than relitigating the claim filed in Skinner, the Court in the instant action should have analyzed the character of Plaintiff 's claim and found it to have been completely preempted and cognizable under ERISA's civil enforcement provisions.

But in thus trying to get out from under the weight of Skinner, HCC has demonstrated why federal subject matter jurisdiction is lacking over the removed claim in all events.

It will be remembered that here a minor--who is not himself a plan beneficiary--has brought a motion in the state court action to be relieved from the assertion of a lien by HCC's assignor (the employee benefit plan). HCC seeks to respond to that motion by pointing to the contractual [*6] obligation of reimbursement undertaken by the minor's mother, who is a plan beneficiary. n3 It is of course entirely permissible for the Illinois courts to hold (as they consistently have) that the minor has no responsibility to reimburse the plan (that is a non-ERISA question and is not ERISA-preempted under the ruling in *Kelleher v. Hood, 238 Ill.App. 3d 842, 850-53, 605 N.E.2d 1018, 1024-26, 179 Ill. Dec. 4 (2d Dist. 1992))*, even though as a contractual matter the mother does have such a responsibility (that is a potential ERISA question, stemming from the terms of the plan). To be sure, that might result in an empty victory in terms of the family unit as a whole--but for current purposes the fact remains that the claim of the minor in the underlying action is not ERISA-based, and that is the test for removal purposes.

> n3 Under that provision of the plan (Demaret Aff. Ex. B) the mother's reimbursement agreement extends to injuries suffered by "covered dependents" (in this case her minor son) as well as to injuries sustained by the plan beneficiary (the mother herself). But under the plan itself the agreement to reimburse is solely that of the mother.

[*7]

Once again HCC seeks to gloss over an adverse factor that controls the case. In this instance that factor is the lack of legal identity between the minor son and his mother--or to be precise, between the mother in her capacity as her son's next friend (in which capacity she has no obligation to the employee benefit plan) and the mother in her own person (a capacity in which she does have a stated contractual obligation to the plan). Because the underlying lawsuit was plainly brought in the former capacity and not the latter, HCC cannot bootstrap itself into an assertedly ERISA-based predicate (based on the mother's obligation qua plan beneficiary) for removal of that lawsuit to this federal court.

Thus whether HCC's attempted assertion of its claimed lien against the settlement proceeds is viewed through the same lens as HCC's misguided effort to bring the Skinner lawsuit (as this Court has suggested at pages 4-5 of the Opinion) or is instead viewed as HCC's attempted resistance to a non-ERISA claim (as just discussed in this opinion), the result remains the same: "the district court lacks subject matter jurisdiction" (Section 1447(c)). This Court's original determination [*8] that the statute mandates a remand to the Circuit Court of Cook County was correct, and the stay of that remand order is therefore lifted. In accordance with this Court's February 25 opinion, the Clerk of Court is directed to mail the certified copy of the remand order forthwith. n4

> n4 HCC's counsel complains that such an order is contrary to what he labels as the "usual" 14-day delay under this District Court's General Rule ("GR") 30(b). That mistakes the purpose of the rule. What GR 30(b) simply says is that if the court

ordering remand is silent on the subject, there will be such a delay--or to put it differently, that the ordering court must express itself affirmatively if it wishes the remand order to take effect either immediately or after a shorter delay period. But the determination as to whether or not there should be any delay is entirely for the ordering court, based on its evaluation of the circumstances of the case.

Milton I. Shadur

Senior United States District Judge

Date: March 2, 1994

1994 U.S. Dist. LEXIS 6320 printed in FULL format.

MARIANJOY REHABILITATION CENTER, Plaintiff, v. MICHAEL MIRTL AND SHARON MIRTL, a/k/a SHARON ARENA, Defendants and CENTRAL STATES, SOUTHEAST AND SOUTHWEST AREAS HEALTH AND WELFARE FUND, Citation Respondents.

MARIANJOY REHABILITATION CTR. v. MIRTL

93 C 5097 Consolidated with 92 C 7304

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS,
EASTERN DIVISION

1994 U.S. Dist. LEXIS 6320

May 12, 1994, Decided

May 13, 1994, Docketed

JUDGES: [*1] NORDBERG

OPINIONBY: JOHN A. NORDBERG

OPINION: MEMORANDUM OPINION AND ORDER

Before the Court are Plaintiff Marianjoy Rehabilitation Center's Motion for a Turnover Order and Respondent

Central States Southeast and Southwest Areas Health and Welfare Fund's Motion for Summary Judgement.

FACTS

The following facts are uncontested. On October 14, 1989, Edward Mirtl was involved in an automobile accident. Michael Mirtl, Edward's father is a former employee of Charles Levy Circulating Company. On March 11, 1990, Charles Levy Circulating Company entered into an agreement for health coverage for their employees and dependents with Central States, Southeast and Southwest Health and Welfare Fund. Consequently, on March 11, 1990, Michael Mirtl became a participant in Central States Southeast and Southwest Areas Health and Welfare Fund ("Central States"). As a dependent of Michael Mirtl, Edward became eligible for benefits under the Central States' health and welfare plan on the same date.

On or about April 24, 1990, a settlement was reached between State Farm Insurance and Sharon Arena, Edward Mirtl's mother, and the Mirtls. Pursuant to the settlement, State Farm Insurance paid Sharon Arena and the Mirtls [*2] the policy limit of $ 100,000 for an uninsured motorist and in return State Farm Insurance received an assignment of all rights of recovery arising out of the October 14, 1989 accident. n1

n1 The driver of the mini-bike, on which Edward Mirtl was riding at the time of the accident, was uninsured.

Plaintiff Marianjoy Rehabilitation Center ("Marianjoy") provided rehabilitation services to Edward Mirtl between

February 16, 1990 and August 17, 1990. Marianjoy billed Central States directly for services rendered. On August 14, 1990, August 16, 1990 and September 5, 1990, Central States made payments to Marianjoy totaling $ 5,790.50 for services rendered between March 3, 1990 and July 20, 1990 to Edward Mirtl. At the time of these payments, Central States was unaware of the settlement between Edward Mirtl and State Farm Insurance. On September 30, 1991, Central States' Subrogation Committee decided that the remainder of claims submitted by Marianjoy were not authorized for payment because Edward Mirtl's assignment of rights [*3] and receipt of $ 100,000.00 pursuant to the settlement with State Farm Insurance. The Subrogation Committee determined that Edward Mirtl's settlement and assignment of rights violated the health and welfare plan's subrogation rules. n2

n2 Central States claims that if Edward Mirtl had not violated the Health and Welfare Plan's subrogation rules, Marianjoy would have received an additional $ 17,422.00 in payments from Central States. On the other hand, Marianjoy claims that it is entitled to payments from Central States totaling $27,054.00.

On August 20, 1992, the Circuit Court of Kane County, Illinois entered judgement in favor of Marianjoy and against Michael Mirtl in the amount of $ 27,054.00 plus costs. Subsequently, on July 27, 1993, pursuant to Section 2-1402 of Illinois Code of Civil Procedure, Marianjoy served a Citation to Discover Assets upon Central States. Central States removed the citation proceeding to this Court asserting that this Court has jurisdiction over the action pursuant to the

Employee Retirement [*4] Income Security Act of 1974 ("ERISA"), *29 U.S.C. § 301* et seq. Marianjoy asks this Court to order Central States to turnover to Marianjoy the sum of $ 27,054.00. Central States opposes Marianjoy's request for a turnover order and argues further that it is entitled to summary judgment because Michael Mirtl has no entitlement to benefits under the health and welfare plan.

Turnover Order

In support of its Motion for a Turnover Order, Marianjoy asserts that the terms and conditions of the health and welfare plan authorize benefits for the services Marianjoy rendered to Michael Mirtl and nothing in the provision regarding subrogation rights allows Central States to avoid payment to a health care provider because the covered individual did not inform Central States or attempt to reimburse Central States from the settlement proceeds for the accident related benefits. Central States responds that the Illinois statute pursuant to which Marianjoy requests the instant turnover order is preempted by ERISA.

Section 2-1402 of the Illinois Code of Civil Procedure permits Marianjoy, as the judgement creditor, to obtain property in Central States' possession [*5] belonging to Edward Mirtl, the judgement debtor, or alternatively, to bring a suit against Central States to recover Central States' purported indebtedness to Edward Mirtl. 735 ILCS 5/2-1402(b)(4) and (6). Central States asserts that as Section 2-1402 is a state law which "relates to" an employee benefit plan it is preempted by ERISA. See, 29 U.S.C. § 1144(a).

Central States' assertion must be rejected as it is in direct conflict with the Supreme Court's holding in *Mackey v. Lanier Collection Agency & Service, 486 U.S. 825, 108 S.Ct. 2182, 100 L. Ed. 2d 836 (1988).* In Mackey, the Supreme Court held that Congress did not intend ERISA to forbid the use of state law mechanisms for executing judgements against ERISA welfare benefit plans, even when those mechanisms prevent plan participants from receiving their benefits. Id. at 430.

Central States' attempt to distinguish Mackey from the present case is equally unavailing. Central States argues that in Mackey, it was undisputed that the judgement-debtor employees had benefits which could be garnished whereas in the present [*6] case, whether the judgement-debtor, Edward Mirtl, is entitled to benefits under the health and welfare plan is disputed. While such an argument is relevant to the issue of whether benefits exist for Marianjoy to collect, it is irrelevant to the issue of whether an Illinois post-judgement collection proceeding is preempted by ERISA. Given the Supreme Court's holding in Mackey, Section 2-2104 of Illinois Code of Civil Procedure is not preempted by ERISA.

However, as a judgement creditor can assert against a garnishee only those claims that the judgement debtor could have maintained against the garnishee, Marianjoy's motion for a turnover order hinges on whether Edward Mirtl can maintain a claim against Central States for benefits for health costs he incurred as a result of his automobile accident. *Seidmon v. Harris, 172 Ill. App. 3d 352, 122 Ill.Dec. 284, 526 N.E.2d 543, 545* (Ill.App. 1 Dist. 1988). Thus, this Court will treat

Marianjoy's Motion for a Turnover Order as the equivalent of a motion for summary judgement.

Motion for Summary Judgement

Summary judgement is appropriate if the pleadings, answers to interrogatories, [*7] affidavits and other materials show "that there is no genuine issue as to any material fact and the parties are entitled to judgement as a matter of law." Fed. R. Civ. P. 56(c). Summary judgement shall be entered against a party who "fails to make a showing sufficient to establish the existence of an essential element to that party's case and on which that party will bear the burden of proof at trial." *Celotex Corp. v. Catrett, 477 U.S. 317, 321, 91 L. Ed. 2d 265, 106 S. Ct. 2548 (1986).* The showing made by the non-moving party must be more than merely colorable. Summary judgement is appropriate "unless there is sufficient evidence favoring the nonmoving party for a jury to return a verdict for that party." *Anderson v. Liberty Lobby, 477 U.S. 242, 249, 91 L. Ed. 2d 202, 106 S. Ct. 2505 (1986).* As the parties do not dispute any material issue of fact, this Court can determine whether Edward Mirtl is entitled to benefits as a matter of law.

However, before this Court determines whether Edward Mirtl is entitled to benefits for health care costs incurred as a result [*8] of his automobile accident, this Court must determine the appropriate standard of review. Central States asserts that this Court should accord the Subrogation Committee great deference in reviewing the Subrogation Committee's decision to deny Edward Mirtl benefit payments. Thus, Central States argues that this Court should reverse the decision of the Subrogation Committee only if

this Court finds the decision to be arbitrary and capricious. Marianjoy claims that the appropriate standard of review is de novo.

In *Firestone Tire and Rubber Co. v. Bruch, 489 U.S. 101, 115, 109 S.Ct. 948, 103 L. Ed. 2d 80 (1989)*, the Supreme Court held that a denial of benefits should be reviewed under a de novo standard unless the benefit plan gives the administrator or fiduciary of the plan discretionary authority to determine eligibility for benefits or to construe the terms of the plan. Article V, Sec. 2 of the Trust Agreement provides:

All questions or controversies, of whatsoever character, arising in any manner or between any parties or persons in connection with the Fund or the operation thereof, whether as to any claim for [*9] benefits preferred by any participant, beneficiary, or any other person, or whether as to the construction of the language or meaning of the rules and regulations adopted by the Trustees, or of this instrument, or as to any writing, decision, instrument or accounts in connection with the operation of the Trust Fund or otherwise, shall be submitted to the trustees, or to a committee of Trustees, and the decision of the Trustees or of such committee thereof shall be binding upon all persons dealing with the Fund or claiming any benefit thereunder. The Trustees are vested with discretionary and final authority in making all such decisions, including Trustee decisions upon claims for benefits by participants and beneficiaries of the Fund and including Trustee decisions construing plan documents of the Fund. To the extent this section is contrary to or inconsistent with the Named Fiduciary Agreement, this section shall be inapplicable.

(Central States' Exhibit A.) Based on the language of the Trust Agreement, Marianjoy argues that as the Subrogation Committee has only one member who is a Health and Welfare Fund Trustee and as there is no indication that the Subrogation Committee was [*10] vested with discretion to interpret the plan document, this Court should apply a de novo standard of review.

In favor of a more deferential standard, Central States references Section 8.02 of the Plan Document. Section 8.02 of the Plan Document provides:

The Trustees shall have the authority to jointly control and manage the operation and administration of the Fund and of this Plan, in accordance with the terms of the Trust Agreement and of this Plan including the authority to allocate fiduciary responsibilities among the Trustees and the authority to designate persons other than Trustees to carry out fiduciary responsibilities in the administration of the Fund and this Plan, except that the Trustees may allocate only to a Committee of Trustees or one (1) or more "investment managers" (as defined by the "Employee Retirement Income Security Act of 1974") investment and other responsibilities relating to assets of the Fund.

(Central States' Exhibit B.) Central States asserts that pursuant to Section 8.02, the Trustees of Health and Welfare Fund established the Subrogation Committee to carry out certain fiduciary responsibilities including consideration of requests for lien [*11] reductions and uniform handling of subrogation matters. (Affidavit of Albert Nelson, Central States' Benefit Services Director, at P 15, Central States'

Exhibit 1.) From the fact that the Subrogation Committee had the authority to consider requests for lien reductions and ensure uniform handling of subrogation matters, Central States concludes that the Subrogation Committee had the discretion to determine whether or not to pay benefits to Marianjoy given Edward Mirtl's $ 100,000.00 settlement. Unfortunately, Central States' conclusion does not follow from its initial assertion. The fact that the Subrogation Committee is responsible for considering hardship requests for lien reductions and for ensuring that subrogation claims are uniformly processed does not suggest that the Subrogation Committee had the discretion to interpret the plan documents and to determine Edward Mirtl's eligibility for benefits. Accordingly, this Court will apply a de novo standard of review.

In ruling on Central States' Motion for Summary Judgement, this Court must address two questions. First, this Court must determine whether Central States has any subrogation rights in the settlement proceeds Edward [*12] Mirtl obtained from State Farm Insurance and second, assuming Central States does have such subrogation rights, this Court must determine the appropriate remedy.

The health and welfare plan's language regarding subrogation rights provides as follows:

In the event the Fund pays benefits for injury, illness or other loss, the Fund shall be subrogated to all rights of recovery the Covered Individual, his or her heirs, guardians, executors, or other representatives may have arising from such injury, illness or other loss. The rights of recovery to which the Fund shall be subrogated include, but are not

limited to, rights against any person or entity that caused, contributed to, or is responsible for the injury, illness or other loss and rights under no fault, personal injury protection, financial responsibility, uninsured or underinsured insurance coverages as well as medical reimbursement insurance coverage not purchased by the Covered Individual.

The Covered Individual and any person acting on his or her behalf shall, on request, provide the Fund with information the Fund deems necessary to pursue and protect its right of subrogation and shall do nothing to prejudice the Fund's right [*13] of subrogation.

The Fund shall not be responsible for expenses or fees incurred in connection with the sums recovered unless the Fund shall have agreed in writing to pay a portion of those expenses or fees. The Fund reserves the right to reduce the amount of the Fund's recoverable interest where circumstances warrant such reduction. The Fund also reserves the right to initiate an action in the name of the Covered Individual or his or her representative to recover its subrogation interest.

(Central States' Exhibit B.)

In support of its Motion for Summary Judgement, Central States asserts that Edward Mirtl violated the clear terms of the health and welfare plan when he received a $ 100,000.00 settlement in return for an assignment of all of his rights of recovery arising out of the automobile accident. Central States argues that the clear language of the Plan Document subrogated to Central States the rights which Edward Mirtl assigned to State Farm Insurance and further required

Edward Mirtl to reimburse Central States, from the settlement proceeds, for accident related benefits paid.

Given the plain language of the subrogation provision which directs that where the Fund pays benefits [*14] for injury, the Fund shall be subrogated to the covered individual's rights of recovery, the Court finds that Central States had a right to the rights which Edward Mirtl assigned to State Farm Insurance, and consequently, Central States has a right in the $ 100,000 which Edward Mirtl received in exchange for the assignment of his rights to State Farm Insurance.

Marianjoy argues that Central States has no subrogation rights in the settlement obtained by Edward Mirtl because Central States did not issue its first payment on behalf of Edward Mirtl until August 14, 1990 approximately four months after the settlement between State Farm Insurance and Edward Mirtl. Thus, Marianjoy asserts that as Edward Mirtl no longer had any rights to recovery when Central States made its first payment, there was nothing to subrogate.

This Court cannot accept Marianjoy's interpretation of the subrogation language in Section 11.14 of the Plan documents because such an interpretation would subvert the very purpose of the Plan Document's provision for subrogation. The Plan Document's subrogation provision grants Central States the right to recover monies paid for charges relating to accidental injuries and [*15] to prevent benefit payments when it is determined that another party is legally responsible for medical expense payments. (Central States' Third Party Subrogation Procedures at 1, Marianjoy's Exhibit J.) As this

is not a case where another party was determined to be legally responsible, Central States has a right to recover monies paid for charges relating to accidental injuries. If this Court were to accept Marianjoy's interpretation of the plan documents, Central States would automatically lose its subrogation rights if it paid benefits after the claims were settled. Any covered individual could nullify Central States' subrogation rights by merely waiting until after it settled its claim before submitting an application to Central States for benefits. Moreover, even if the covered individual did not purposely delay his application for benefits, Central States would lose its right to subrogation if the covered individual simply settled the claims before Central States had a chance to review the covered individual's application for benefits and determine if that application implicated subrogation rights. The speed at which a case settles should not control Central States' ability [*16] to preserve its subrogation rights especially where there is no indication that Central States unduly delayed its assessment of benefit claims. n3

n3 The Court cannot determine from the attached materials the date on which Marianjoy submitted its claims to Central States for services rendered on behalf of Edward Mirtl. However, the Court notes that for services rendered by Marianjoy between March 29, 1990 and July 20, 1990, Central States issued payments on August 14, 1990, August 16, 1990 and September 5, 1990. (Marianjoy Statement of Material Facts at P 9.)

Having determined that Central States does have a right in the settlement proceeds, the more difficult question which the

Court must decide is the appropriate remedy. Central States contends that Edward Mirtl prejudiced Central States' subrogation rights when neither he nor his representatives informed Central States of the possibility of settlement or attempted to reimburse Central States, from the proceeds of the settlement, for the $ 5,790.00 in accident related [*17] benefits which Central States already paid. Central States asserts that Edward Mirtl's failure to inform or reimburse Central States violated the terms of the plan documents which state "the Covered individual . . . shall do nothing to prejudice the Fund's right to subrogation." (Section 11.14 of the Plan Document, Central States' Exhibit B.)

However, the Court finds it significant that nothing in the plan documents directs a plan participant to notify Central States about possible settlements regarding accident related injuries or to reimburse Central States for accident related benefits already paid. If this Court were to hold that, because Edward Mirtl or his representative did not inform Central States of the possibility of settlement or attempt to reimburse Central States, Edward Mirtl forfeits his right to benefits, then this Court puts the burden on the covered individual to interpret ambiguous terms in the plan documents. No where in the plan documents does Central States suggest what a covered individual must do to avoid prejudicing Central States' subrogation rights and maintain the covered individual's right to benefits.

Forcing the covered individual or his representative [*18] to interpret ambiguous provisions in the plan documents at the risk of losing an otherwise valid claim to benefits would be contrary to Section 1022(b) and to Seventh Circuit case law. ERISA section 1022(b) directs that the plan description

and summary plan description contain information regarding circumstances which may result in disqualification, ineligibility, or denial or loss of benefits. *29 U.S.C. § 1022(b)*. Moreover, the Seventh Circuit has adopted the contract interpretation rule requiring courts to construe ambiguous terms in an insurance contract strictly in favor of the insured as the federal common law of ERISA. *Phillips v. Lincoln National Life Ins. Co., 978 F.2d 302, 311 (7th Cir. 1992)*. In Phillips, the Seventh Circuit stated,

Insurance policies are almost always drafted by specialists employed by the insurer. In light of the drafter's expertise and experience, the insurer should be expected to set forth any limitations on its liability clearly enough for a common lay person to understand; if it fails to do this, it should not be allowed to take advantage of the very ambiguities that it could [*19] have prevented with greater diligence.

Id. at 312 (citing *Kunin v. Benefit Trust Life Insurance Company, 910 F.2d 534, 540* (9th Cir.), cert. denied, *498 U.S. 1013, 111 S.Ct. 581, 112 L. Ed. 2d 587 (1990)*. By holding that Edward Mirtl cannot be denied benefits where the plan documents do not indicate what acts might prejudice Central States or what precautionary measures a covered individual must take to avoid prejudicing Central States' right to subrogation, this Court puts the burden on Central States to clearly set out circumstances which may produce a loss of benefits. Putting the burden on Central States to clearly set out circumstances which may produce a loss of benefits is consistent with § 1022(b) and with the Seventh Circuit's holding in Phillips.

As this Court holds the proper remedy for Central States' loss of its right to subrogation is not a denial of Edward Mirtl's benefits, Marianjoy, as the service provider and as Edward Mirtl's judgement creditor, is entitled to have its claims paid in accordance with the plan provisions. Central States [*20] could have protected its right to subrogation by putting a provision in the plan documents which conditioned medical coverage for accident related injuries on the covered individual's obligation to inform Central States of any potential settlements and to reimburse Central States from the settlement proceeds for any accident related benefits already paid. As Central States did not set forth protective measures in the plan documents, its only possible remedy is to bring an action against Edward Mirtl or his representative to recoup any of the settlement proceeds to which it is entitled.

CONCLUSION

For the foregoing reasons, Central States' Motion for Summary Judgement is denied. Marianjoy's Motion for A Turnover Order is granted and accordingly, the parties shall submit memoranda, with supporting affidavits and exhibits, addressing which portions of the claims submitted by Marianjoy for services rendered on behalf of Edward Mirtl are payable under the plan provisions.

Marianjoy shall submit its memorandum by June 2, 1994. Central States shall submit its response by June 23, 1994 and Marianjoy shall submit its reply to Marianjoy's response by July 7, 1994.

ENTER:

JOHN A. NORDBERG [*21]

United States District Judge

DATED: May 12, 1994

1993 U.S. Dist. LEXIS 16105 printed in FULL format.

RICK L. POPLE, individually and as Father and next friend of SARA M. POPLE, a minor, Plaintiffs, v. MARK E. COX and HEALTH COST CONTROLS, INC., Defendants.

POPLE v. COX

No. 93 C 6274

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS,
EASTERN DIVISION

1993 U.S. Dist. LEXIS 16105

November 9, 1993, Decided

November 12, 1993, Docketed

JUDGES: [*1] Conlon

OPINIONBY: SUZANNE B. CONLON

OPINION: MEMORANDUM OPINION AND ORDER

Rick L. Pople ("Rick"), individually and as father and next friend of Sara M. Pople, a minor ("Sara"), (collectively "Pople") sues Mark E. Cox ("Cox") to recover for personal injuries sustained by Sara as a result of an automobile accident involving Sara and Cox. Health Cost Controls, Inc.

("HCC"), the collection agent for the health plan sponsored by Rick's employer, Abbott Laboratories ("Abbott"), removed the case to federal court. Pople moves to remand this action to the Circuit Court for the Nineteenth Judicial District, Lake County, Illinois.

BACKGROUND

Sara Pople was a passenger in a car driven by Cox on November 15, 1992. Resp., Exh. 1, Complaint P 1. When Cox swerved to avoid hitting an animal that had darted onto the road, the car left the road, rolled over, and hit a tree. Id. at P 3-4. Sara suffered a broken neck. Id. at P 5. The medical bills for Sara's care exceed $ 60,000. Id. at P 2.

Rick Pople works for Abbott and participates in the health care plan sponsored by Abbott for its employees and their dependents ("the plan"). At the time of Sara's injuries, she was 16 years old and thus was [*2] covered as a dependent under the plan. The plan is an employee welfare benefit plan within the meaning of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), *29 U.S.C. § 1002(1)*. The plan contains a subrogation and reimbursement provision that states in pertinent part:

In the event of any payment under the Plan, the Company shall be subrogated to all the Covered Employees' and their respective Dependents' rights of recovery against any person or organization liable to such Employee or Dependent for the injuries on account of which such payments are made. This right of recovery shall apply to all rights of recovery whatsoever, including but not limited to rights of recovery

based on negligent or intentional bodily injury, product liability and medical malpractice.

Resp., Exh. B, P 13.15 of the plan.

Pople filed a personal injury action against Cox in state court. Count I seeks damages for Sara for her past and future medical bills, past and future disability and past and future pain and suffering. Count II seeks damages for Rick for the medical expenses he incurred. HCC filed a lien on the proceeds of any judgment [*3] or settlement in the personal injury action on behalf of Abbott. Pople filed a petition to adjudicate HCC's claimed lien on September 27, 1993, and a hearing date was set for October 18, 1993. Pople admitted in his petition that HCC's lien would apply to any recovery by Rick under Count II but contended that HCC's right to any recovery by Sara under Count I is barred by the Illinois Family Expense Act, 750 ILCS 65/15.

On October 15, 1993, HCC removed the case to this court, claiming this court has federal jurisdiction under ERISA. Pople contends the case was wrongly removed and moves for remand to state court.

DISCUSSION

Pople asserts that ERISA is only tangentially implicated in this case and that federal law does not govern; thus, the removal was improper. Specifically, Pople argues that (1) ERISA does not preempt state law; (2) HCC's petition to adjudicate its purported lien is not a civil action within the civil remedies provision of ERISA; and (3) HCC does not

have standing to bring a civil action under ERISA. Pople's arguments all fail, and Pople's motion to remand is denied.

First, ERISA does preempt state law here. The Supreme Court explained the relationship between [*4] ERISA and state law in *Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 95 L. Ed. 2d 39, 107 S. Ct. 1549 (1987)*. ERISA includes three provisions relating to preemption of state claims: the preemption clause, the saving clause and the deemer clause. *Pilot Life Ins., 481 U.S. at 44-45*. The preemption clause states:

Except as provided in subsection (b) of this section [the saving clause], the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan. . . .

29 U.S.C. § 1144(a). The saving clause states:

Except as provided in subparagraph (B) [the deemer clause], nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

29 U.S.C. § 1144(b)(2)(A). The deemer clause states:

Neither an employee benefit plan . . . nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or [*5] to be engaged in the business of insurance or banking for purposes of any law of any State

purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

29 U.S.C. § 1144(b)(2)(B). In summary, ERISA preempts state laws relating to employee benefit plans; the saving clause excepts from preemption those state laws that regulate insurance; and the deemer clause prevents a state law that purports to regulate insurance from deeming an employee benefit plan to be an insurance company. *Pilot Life Ins., 481 U.S. at 45.*

The scope of federal preemption of state law turns on the meaning of "relates to" in the preemption clause. The Supreme Court has held that "relates to" should be broadly construed, explaining that:

The pre-emption clause is conspicuous for its breadth. . . . Congress used those words ["relate to"] in their broad sense, rejecting more limited pre-emption language that would have made the clause applicable only to state laws relating to the specific subjects covered by ERISA. . . .

A law "relates to" an employee benefit plan, in the normal sense of the [*6] phrase, if it has a connection with or reference to such a plan. Under this broad common-sense meaning, a state law may "relate to" a benefit plan, and thereby be pre-empted, even if the law is not specifically designed to affect such plans, or the effect is only indirect.

Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 138-39, 112 L. Ed. 2d 474, 111 S. Ct. 478 (1990) (citations omitted) (emphasis added).

The Supreme Court explained ERISA's interaction with state law in a situation similar to this one in *FMC Corp. v. Holliday, 498 U.S. 52, 54-55, 112 L. Ed. 2d 356, 111 S. Ct. 403 (1990)*. Cynthia Ann Holliday was seriously injured in a car accident. Cynthia's father, Gerald, worked for FMC Corporation ("FMC") and participated in FMC's self-funded employee welfare benefit plan ("the plan"), which provided health benefits to FMC employees and their dependents. The plan paid part of Cynthia's medical expenses. Gerald brought a negligence action in Pennsylvania state court against the driver of the car in which Cynthia was injured. While the suit was pending, FMC notified the Hollidays that it would seek reimbursement for medical costs it had paid. The Hollidays contended that a Pennsylvania [*7] statute precluded subrogation by FMC. The Supreme Court disagreed.

The Court noted that the Pennsylvania statute fell within the ERISA's saving clause, because the statute controlled the terms of insurance contracts by invalidating subrogation provisions. *Id. at 61*. However, the Court held that the state law was preempted nonetheless because the plan was self-funded and thus not an insurance company within the meaning of the saving clause. The Court explained the interplay between the saving clause and the deemer clause and the important distinction between self-funded ERISA plans and insurance companies:

We read the deemer clause to exempt self-funded ERISA plans from state laws that "regulate insurance" within the meaning of the saving clause. By forbidding States to deem employee benefit plans "to be an insurance company or other insurer . . . or to be engaged in the business of insurance," the deemer clause relieves plans from state laws "purporting

to regulate insurance." As a result, self-funded ERISA plans are exempt from state regulation insofar as that regulation "relate[s] to" the plans. State laws directed toward the plans are pre-empted [*8] because they relate to an employee benefit plan but are not "saved" because they do not regulate insurance. State laws that directly regulate insurance are "saved" but do not reach self-funded employee benefit plans because the plans may not be deemed to be insurance companies, other insurers, or engaged in the business of insurance for the purposes of state laws.

Id. FMC Corp. means that self-funded employee benefit plans are controlled by ERISA; state regulation is preempted to the extent it "relates to" self-funded plans. This disparate, seemingly arbitrary treatment of self-funded plans has been noted and approved by the Court:

We are aware that our decision results in a distinction between insured and uninsured plans, leaving the former open to indirect regulation while the latter are not. By so doing we merely give life to a distinction created by Congress in the "deemer clause," a distinction Congress is aware of and one it has not chosen to alter.

Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 747, 85 L. Ed. 2d 728, 105 S. Ct. 2380 (1984).

This case is almost entirely controlled by FMC Corp. since it also involves a self-funded plan. Resp. at 5-6. [*9] The facts are almost identical. The only wrinkle is the difference between the Pennsylvania and Illinois state laws. The Pennsylvania law at issue in FMC Corp. specifically concerned subrogation. The Illinois Family Expense Act

("the Act") does not on its face relate to employee benefit plans.

The Act states: "The expenses of the family and of the education of the children shall be chargeable upon the property of both husband and wife, or either of them, in favor of creditors therefor, and in relation thereto they may be sued jointly and separately." 750 ILCS § 65/15. Illinois courts have considered the Act in the context of children's medical costs. Under the Act, parents are liable for medical costs for their minor children. *Estate of Hammond v. Aetna Casualty, 141 Ill. App. 3d 963, 491 N.E.2d 84, 85-86, 96 Ill. Dec. 270 (1986); Estate of Woodring v. Liberty Mut. Fire Ins. Co., 71 Ill. App. 3d 158, 389 N.E.2d 211, 212, 27 Ill. Dec. 399 (1979).* Since the responsibility for medical expenses lies with a child's parents, only the parents can bring suit to recover the medical expenses. *Hammond, 491 N.E.2d at 86.* [*10] Therefore, a health insurance company that pays for the medical care of a dependent of a subscriber parent has no right of subrogation or reimbursement against the minor's estate. Id.

Since ERISA defines "state law" as "all laws, decisions, rules, regulations, or other state action having the effect of law," decisions interpreting the Act are included in "state law." *29 U.S.C. § 1144(c)(1).* Thus, the Act involves subrogation and relates to employee benefit plans in the broad sense mandated by the Supreme Court. Since the Act "relates to" employee benefit plans, the Act is preempted by ERISA and federal jurisdiction is proper. This conclusion is supported by recent decisions in this Circuit. See, e.g., *Reilly v. Blue Cross & Blue Shield United of Wisconsin, 846 F.2d 416, 424-26 (7th Cir.),* cert. denied, *488 U.S. 856, 102 L.*

*Ed. 2d 117, 109 S. Ct. 145 (1988); Sanders v. Scheideler, 816 F. Supp. 1338, 1346 (W.D. Wis. 1993); Serembus on Behalf of UIU v. Mathwig, 817 F. Supp. 1414, 1420-21 (E.D. Wis. 1992); Cutting v. Jerome Foods, Inc., 820 F. Supp. 1146, 1150-51 (W.D. Wis. 1991), [*11] aff'd, 993 F.2d 1293 (7th Cir. 1993)*, cert. denied, *114 S. Ct. 308, 125 L. Ed. 2d 255 (1993); Dugan v. Nickla, 763 F. Supp. 981, 983 (N.D. Ill. 1991).*

Regarding Pople's other arguments, the petition to adjudicate HCC's lien is a civil action within the civil remedies provision of ERISA and HCC has standing to bring a civil action under ERISA. HCC is a fiduciary within the meaning of *29 U.S.C. § 1002(21)*, so HCC may bring an action to enforce its lien pursuant to *29 U.S.C. § 1132(a)(3)*. Pople's reliance on *In re Estate of Sheppard, 658 F. Supp. 729 (C.D. Ill. 1987)* is misplaced, since Shepard involved an enforcement action brought by an employer under *29 U.S.C. § 1132(a)(1)(B)* as a beneficiary.

However, under *29 U.S.C. § 1132(a)(3)*, a fiduciary may bring suit only for injunctive or equitable relief, not to recover benefits or monies. HCC's lien petition is nonetheless proper because HCC brings its action pursuant to this court's federal [*12] question jurisdiction, *28 U.S.C. 1331*, as well as *29 U.S.C. § 1132(a)(3)*. Congress intended that courts create federal common law under ERISA. *Dugan, 763 F. Supp. at 982*, citing *Firestone Tire and Rubber Co. v. Bruch, 489 U.S. 101, 110, 103 L. Ed. 2d 80, 109 S. Ct. 948 (1989)*. A claim based on federal common law may be brought under federal question jurisdiction. Id. (citation omitted). Thus, HCC's claim is properly before this court even though the claim does not fall under *29 U.S.C. §*

1132(a)(3)'s more limited grant of jurisdiction. Id. at 983 (citations omitted).

CONCLUSION

Plaintiff Pople's motion to remand is denied. Defendant Cox is directed to answer by November 23, 1993. Discovery is to be completed and any dispositive motions filed by February 2, 1994. The parties are directed to file their joint final pretrial order in open court on February 23, 1994 at 9:00 a.m. The case is set on the March trial calendar. Counsel are advised that all dates are firm.

ENTER:

Suzanne B. Conlon

United States District Judge

November 9, [*13] 1993

906 F.2d 985 printed in FULL format

PROVIDENT LIFE ACCIDENT INSURANCE COMPANY, Plaintiff-Appellant, v. MARY J. WALLER, Defendant-Appellee.
PROVIDENT LIFE & ACCIDENT INSURANCE COMPANY, Plaintiff-Appellee, v. MARY J. WALLER, Defendant-Appellant

PROVIDENT LIFE & ACCIDENT INS. CO. v. WALLER

Nos. 89-2123, 89-2124

UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

906 F.2d 985;
1990 U.S. App. LEXIS 10813;
12 E.B.C. 1880

March 6, 1990, Argued

June 27, 1990, Decided

SUBSEQUENT HISTORY: [**] As Amended July 10, 1990.

PRIOR HISTORY:
Appeals from the United States District Court for the Western District of

Virginia, at Roanoke. James C. Turk, Chief District Judge. CA-88-0173-R.

DISPOSITION: REVERSED.

COUNSEL: Argued: William Hitchcock Lindsey, Bounds & Dorsey, P.C., Roanoke, Virginia, for Appellant.

W. Carrington Thompson, Chatham, Virginia, for Appellee. On Brief: Thomas L. Phillips, Phillips, Phillips & Phillips, Rustburg, Virginia for Appellee.

JUDGES: Murnaghan, Circuit Judge, Butzner, Senior Circuit Judge, and Kaufman,
Senior United States District Judge for the District of Maryland, sitting by
designation.

OPINIONBY: MURNAGHAN

OPINION: [*986] MURNAGHAN, Circuit Judge.

We are presented with several difficult questions regarding the scope of the
Employee Retirement Income Security Act of 1974 ("ERISA") and the power of the
federal courts to fill in the interstices of this comprehensive and labyrinthine
statute. Specifically, we address whether the Provident Life & Accident
Insurance Co. ("Provident") may recover monies advanced to one of its plan

participants, Mary J. Waller, after she was injured in an auto accident. In response to Provident's action under ERISA for recovery of the advanced benefits, the district court concluded that Provident was not entitled to reimbursement because it did not comply with one of the provisions of the ERISA-governed plan. On Provident's appeal, we conclude that a failure to repay this advance would unjustly enrich Waller and contradict the intent of both ERISA and the plan. Accordingly, we reverse the order of the district court and enter judgment for Provident.

I.

Waller was employed by Burlington Industries and a participant in its qualified self-funded employee benefit plan, which is administered by Provident. The plan pays life, medical and disability benefits to or on behalf of its participants, such as Waller. However, the plan specifically provides in an "Acts of Third Parties" provision that

> Medical and disability benefits are not payable to or for a person covered under the Group Plan when the injury or illness to the covered person occurs through the act or omission of another person. However, payment for medical care expenses . . . for an injury or illness in which a third party is liable may be advanced by Provident. For this to happen, the covered person must sign an agreement to

repay the Group Plan in full any payments advanced . . . from the judgment or settlement he or she receives. . . .

(Emphasis added.)

On February 21, 1986, Waller was injured in a car accident in which she was not at fault. On Waller's written request, Provident advanced her $ 5,922.53 in medical expenses despite never obtaining a signed repayment agreement. n1 Waller later recovered damages from the third party in excess of what the plan paid out to her. After Waller refused to reimburse the [*987] plan, Provident brought an action under ERISA, 29 U.S.C. § 1132(a)(1)(B), (e)(2) (1982), for recovery of the advanced monies plus costs and attorney's fees. Although admitting to receiving the money from a third party, n2 Waller filed an answer questioning the district court's jurisdiction under § 1132(a)(1)(B). She also filed a counterclaim under § 1132(a)(1)(B) requesting a declaratory judgment that the Virginia anti-subrogation statute, Va.Code Ann. § 38.2-3405, precluded reimbursement and was not preempted by ERISA. Finally, Waller requested class certification on behalf of all plan beneficiaries who had repaid money advanced by Provident.

n1 The record is silent on why the agreement was never signed by Waller. Provident states only that the benefits were advanced "at [Waller's] request." Appellant's Br. at 3.

[**4]

n2 An affidavit submitted by Burlington's group benefits manager demonstrated that Waller also knew of the "Acts of Third Parties" provision.

The district court denied Waller's motion to certify the class but denied Provident's motion for summary judgment and entered judgment in favor of Waller. The district court found that although ERISA preempted the Virginia anti-subrogation provision, Provident's failure to require Waller to sign the repayment provision constituted noncompliance with the terms of the plan and therefore barred its recovery of advanced expenses. Provident appeals that conclusion and Waller appeals the district court's denial of class certification.

II.

In its complaint, Provident alleged federal jurisdiction under ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B) (West 1985). Waller maintains that § 1132(a)(1)(B) does not provide a federal cause of action for plan administrators. We agree, but nonetheless conclude that the district court had jurisdiction under the federal question provision.

A.

Section 1132(a)(1)(B) provides, in relevant part, that "[a] civil action may be brought . . . by a participant or beneficiary . . . to recover benefits due him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan" (emphasis added). Here, Provident was neither a participant nor beneficiary but rather the administrator of Burlington's self-funded plan. n3 Although we have not yet addressed the scope of § 1132(a), most of our sister circuits have limited federal jurisdiction to the suits by the entities specified in the statute. See, e.g., Hermann Hosp. v. MEBA

Medical & Benefits Plan, 845 F.2d 1286, 1288-89 (5th Cir. 1988) ("Where Congress has defined the parties who may bring a civil action founded on ERISA, we are loathe to ignore the legislature's specificity."); Pressroom Unions-Printers League Income Security Fund v. Continental Assurance Co., 700 F.2d 889, 892 (2d Cir.) ("legislature [did not] intend[] to grant subject matter jurisdiction over suits by employers, funds, or other parties not listed in § 1132[a]. . . ."), cert. denied, 464 U.S. 845, 78 L.Ed.2d 138, 104 S. Ct. 148 (1983). n4 Such a conclusion is amply supported by the Supreme Court's decision in Franchise Tax [**6] Board v. Construction Laborers Vacation Trust, 463 U.S. 1, 21, 77 L.Ed.2d 420, 103 S. Ct. 2841 (1983), which noted that "the express grant of [*988] federal jurisdiction in ERISA is limited to suits brought by certain parties . . . as to whom Congress presumably determined that a right to enter federal court was necessary to further the statute's purposes." Finally, at least two courts specifically have concluded that plan administrators may not bring suit under § 1132(a)(1)(B) of ERISA. See Great Lakes Steel v. Deggendorf, 716 F.2d 1101, 1104 (6th Cir. 1983); In Re Sheppard, 658 F. Supp. 729, 734 (C.D.Ill. 1987). We find ourselves in agreement with this view, and so conclude that Provident cannot bring suit under § 1132(a)(1)(B). n5

n3 In the "definitions" section of ERISA, the term "participant" is described as "any employee . . . who is or may become eligible to receive a benefit of any type from an employee benefit plan. . . ." 29 U.S.C.A. § 1002(7) (West Supp. 1990). A beneficiary is described as "a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit

thereunder." 29 U.S.C.A. § 1002(8) (West Supp. 1990). The term "administrator" means "the person specifically so designated by the terms of the instrument under which the plan is operated; [or] . . . the plan sponsor. . . ." 29 U.S.C.A. § 1002(16)(A) (West Supp. 1990).

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n4 The only circuit holding a contrary view is the Ninth, which held in Fentron Indus. v. National Shopmen Pension Fund, 674 F.2d 1300, 1304 (9th Cir. 1982), that certain "non-enumerated" parties have standing to sue under § 1132(a)(1)(B). However, Fentron has been widely criticized and narrowed within its own circuit. See Associated Builders & Contractors v. Carpenters Vacation & Holiday Trust Fund, 700 F.2d 1269, 1278 (9th Cir.) (limiting Fentron to confer standing only where "specific and personal" injuries alleged), cert. denied, 464 U.S. 825, 78 L.Ed.2d 101, 104 S. Ct. 94 (1983).

n5 It is probable, however, that Provident could have sued under § 1132(a)(3), which provides that "[a] civil action may be brought . . . by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan.

29 U.S.C.A. § 1132(a)(3) (West 1985) (emphasis added). Recently, we concluded in an analogous ERISA situation that

a plan administrator "is clearly a fiduciary." U.S. Steel Mining Co. v. District 17, United Mine Workers of America, 897 F.2d 149, 152 (4th Cir. 1990). That conclusion is bolstered by a recent Department of Labor regulation, which states that "a plan administrator . . . must, by the very nature of his position, have 'discretionary authority [and fiduciary status].'" 29 C.F.R. § 2509.75-8 (1989).

[**8]

B.

Ordinarily, the failure to state the federal statutory or constitutional provision under which a claim arises warrants dismissal for lack of subject matter jurisdiction. However, it is well settled that courts may excuse pleading defects if the facts alleged in the complaint and the relief requested demonstrate the existence of a substantial federal question. See Schlesinger v. Councilman, 420 U.S. 738, 744 n.9, 43 L.Ed.2d 591, 95 S. Ct. 1300 (1975) (§ 1331 "nowhere mentioned" in complaint but facts "demonstrate the existence of a federal question"); Blue v. Craig, 505 F.2d 830, 844 (4th Cir. 1974) ("If facts giving the court jurisdiction are set forth in the complaint, the provision conferring jurisdiction need not be specifically pleaded.") (quoting Williams v. United States, 405 F.2d 951, 954 (9th Cir. 1969)); 5 C. Wright & A. Miller, Federal Practice & Procedure: Civil § 1209, at 92 (1969 & Supp. 1989) ("failure to name the particular statute . . . under which the action arises is not fatal if the remainder of the complaint shows that a federal question actually is involved or relied upon by the pleader"). We believe that the balance of Provident's complaint

demonstrates that a federal question is involved, see 28 U.S.C. § 1331(a) (1982). n6

> n6 Although the ERISA provision not referred to in Provident's complaint, 29 U.S.C. § 1132(a)(3), may also provide a route to federal jurisdiction, there is seemingly little or no authority with regard to that question. Accordingly, in this case, we prefer to ground federal jurisdiction under the federal question provision.

Section 1331(a) provides that district courts "shall have original jurisdiction of all civil actions arising under the Constitution, laws or treaties of the United States." A suit "arises under" federal law if federal law creates the cause of action. American Well Works Co. v. Layne & Bowler Co., 241 U.S. 257, 260, 60 L. Ed. 987, 36 S. Ct. 585 (1916); Cook v. Georgetown Steel Corp., 770 F.2d 1272, 1274 n. 2 (4th Cir. 1985). Although the issue was at one point in doubt, see T.B. Harms Co. v. Eliscu, 339 F.2d 823, 827-828 (2d Cir. 1964) (Friendly, J.), cert. denied, 381 U.S. 915, 14 L.Ed.2d 435, 85 S. Ct. 1534 [**10] (1965), there is no longer any question that the word "laws" in § 1331(a) embraces claims founded upon federal common law. In Illinois v. City of Milwaukee, 406 U.S. 91, 100, 31 L.Ed.2d 712, 92 S. Ct. 1385 (1972), the
Supreme Court concluded that "§ 1331 jurisdiction will support claims founded upon federal common law as well as those of a statutory origin." City of Milwaukee involved a public nuisance suit brought by the State of Illinois against four Wisconsin cities and a city sewage commission for dumping raw sewage into Lake Michigan. The Court, asked to exercise its original jurisdiction because a state was a

party, declined but instead found federal question [*989] jurisdiction. The Court held that because Congress had federalized the area of water pollution with the Water Pollution Control Act of 1972, federal courts could impose remedies that fell within the interstices of this act using a federal common law of nuisance. The Court concluded that such a suit arose under the "laws" of the United States. 406 U.S. at 100-04.

Citing City of Milwaukee, several courts have held that ERISA actions governed by federal common law "arise under" federal law for purposes of § 1331. See Airco Industrial Gases v. Teamsters Health & Welfare Pension Fund, 850 F.2d 1028, 1033 (3d Cir. 1988); Whitworth Bros. Storage Co. v. Central States Pension Fund, 794 F.2d 221, 236 (6th Cir.), cert. denied, 479 U.S. 1007, 107 S. Ct. 645, 93 L.Ed.2d 701 (1986); Northeast Dep't ILGWU v. Teamsters Local Union No. 229, 764 F.2d 147, 154-159 (3d Cir. 1985) (opinion of Becker, J.). Cf. Award Service, Inc. v. Northern Calif. Retail Clerks Unions, 763 F.2d 1066, 1068 (9th Cir. 1985) (district court had § 1331 jurisdiction for purposes of determining whether employer had implied cause of action under ERISA), cert. denied, 474 U.S. 1081, 88 L.Ed.2d 890, 106 S. Ct. 850 (1986). One commentator has cited City of Milwaukee for the proposition that "federal common law supports federal question jurisdiction in the district courts in exactly the same way as other federal law does." Field, Sources of Law: The Scope of Federal Common Law, 99 Harv.L.Rev. 881, 897 (1986); see also Merrill, The Common Law Powers of Federal Courts, 52 U.Chi.L.Rev. 1, 40-46 (1985).

As to the situation presented sub judice, both Airco Industrial Gases and Whitworth are particularly instructive. In Airco, an employer sued an employee benefit plan [**12] seeking to recover, under the equitable doctrine of unjust enrichment, overpayments made by mistake. After the district court found federal question jurisdiction and granted relief for the plaintiff, the Third Circuit affirmed on the jurisdictional point. Writing for a unanimous panel, Judge Higginbotham stated that ERISA's broad preemption provision, 29 U.S.C. § 1144(a), "require[s] the application of federal legal principles for its disposition in this case, that is, federal common law principles." 850 F.2d at 1033. Thus, the court concluded that "we agree with [the district court's] conclusion that section 1331 conferred upon it subject matter jurisdiction to determine the existence of a federal common law cause of action based on unjust enrichment." Id. at 1034 (emphasis added).

Similarly, in Whitworth, an employer sued under the contract doctrine of restitution to recover payments mistakenly made to a retirement plan. Because the employer was neither a plan participant, beneficiary, or fiduciary, the Sixth Circuit concluded that the plaintiff could not premise jurisdiction on the face of the ERISA statute. 794 F.2d at 227. However, because the restitution claim could only be decided under federal common law given ERISA's preemption clause, the court held that plaintiff's claims "arise under federal law pursuant to 28 U.S.C. § 1331." Id. at 233.

As in Airco and Whitworth, this appeal presents an application of federal common law. There is little question that Provident's claim of unjust enrichment may not be predicated on state law given ERISA's broad preemption

provision. n7 See 29 U.S. [*990] C.A. § 1144(a) (West 1985) ("the provisions of [ERISA] shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan. . . ."). The Supreme Court has interpreted this provision to preempt state common law contract and tort claims because they "relate to" an employee benefit plan, see Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 47, 95 L.Ed.2d 39, 107 S. Ct. 1549 (1987); Metropolitan Life Ins. Co. v. Taylor, 481 U.S. 58, 62, 95 L.Ed.2d 55, 107 S. Ct. 1542 (1987), and we cannot see how a different result could ensue from a claim for unjust enrichment. See Airco Industrial Gases v. Teamsters Health & Welfare Pension Fund, 618 F. Supp. 943, 950 n. 6 (D.Del. 1985) ("existence of a federal common law action for unjust enrichment preempts plaintiff's claimed state law action"). Having established ERISA's applicability, we must then focus on common law remedies because ERISA does not provide an explicit remedy for Provident. Although it has been well recognized for years, both the Supreme Court and this circuit recently gave express authorization for federal courts to "develop a 'federal common law of rights and obligations under ERISA-regulated plans.'" Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 109 S. Ct. 948, 954, 103 L.Ed.2d 80 (1989) (quoting Pilot Life, 481 U.S. at 56); see also U.S. Steel Mining Co. v. District 17, United Mine Workers of America, 897 F.2d 149, 152 (4th Cir. 1990) ("the drafters of ERISA authorized courts to develop federal common law"). Here, we must undertake precisely the task outlined in Firestone and already performed in a different context in Steel Mining, i.e., develop and add to the growing federal common law of ERISA rights and obligations.

n7 A question does exist, however, as to whether ERISA preempts the Virginia anti-subrogation provision, Va.Code Ann. § 38.2-3405 (Michie 1986 Repl.). Provident argues, and the district court agreed, that preemption is appropriate; conversely, Waller contends that the Virginia provision is controlling and requires a judgment in her favor. Despite the district court's finding that the anti-subrogation statute "without reservation" meets the test for preemption outlined in Shaw v. Delta Air Lines, 463 U.S. 85, 97-99, 77 L. Ed. 2d 490, 103 S. Ct. 2890 (1983), we note that the issue of whether state anti-subrogation provisions are preempted by ERISA has divided the courts. Compare FMC Corp. v. Holliday, 885 F.2d 79, 89-90 (3d Cir. 1989) (ERISA did not preempt Pennsylvania anti-subrogation provision because law did not address a "core type of ERISA matter"), cert. granted, 493 U.S. 1068, 110 S. Ct. 1109, 107 L.Ed.2d 1017, 58 U.S.L.W. 3513 (1990), with United Food & Commercial Workers & Employers Arizona Health & Welfare Trust v. Pacyga, 801 F.2d 1157, 1160 (9th Cir. 1986) (Arizona's anti-subrogation law "relates to" benefit plans and so is preempted).

We are saved from weighing in on the issue because we conclude that no subrogation situation is presented here. Typically, subrogation in the tortfeasor context involves the insurer stepping into the shoes of the insured and attempting to recover from the third party who caused the injury. See 16 Couch on Insurance 2d § 61:172 (Rev.ed. 1983). The instant case, however, concerns a dispute over the terms of the

insurance contract itself, and this contract does not provide for subrogation against a third party. All Provident seeks here is the money it paid out to the insured; it does not seek to step into Waller's shoes and proceed against the third party tortfeasor. Consequently, the Virginia anti-subrogation provision is inapplicable, and so we do not reach the preemption issue.

In light of that consideration, if preemption through ERISA had not occurred and we were thrown back on the Virginia law, the situation, as later explanation in the opinion indicates, is one calling for application under Virginia law of unjust enrichment principles.

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> Our holding today that the creation of ERISA federal common law establishes "arising under" jurisdiction is not without boundaries, however. The mere invocation by a plaintiff of § 1331 and federal common law is not enough, by itself, to confer federal question jurisdiction. For example, a more specific statutory provision conferring exclusive jurisdiction elsewhere would supersede the application of § 1331. E.g., Connors v. Amax Coal Co., 858 F.2d 1226, 1230 (7th Cir. 1988) (Longshore and Harbor Workers' Compensation Act supplants application of § 1331 and ERISA in disputes concerning specific medical expenses). Rather, we hold, as did the Third Circuit in Airco, 850 F.2d at 1033, that federal question jurisdiction exists pursuant to ERISA only where the issue in dispute is of

"central concern" to the federal statute. Such a conclusion is supported both by Franchise Tax Board v. Construction Laborers Vacation Trust, 463 U.S. 1, 77 L. Ed. 2d 420, 103 S. Ct. 2841 (1983), and Shaw v. Delta Air Lines, 463 U.S. 85, 77 L. Ed. 2d 490, 103 S. Ct. 2890 (1983), two cases decided the same day that address the existence of federal jurisdiction over claims that relate to ERISA.

In Franchise Tax Board, a state taxing authority brought suit [**16] against an ERISA-qualified benefit trust fund seeking damages and a declaration that its authority to levy was not preempted by ERISA. Despite the fact that the state did not fall within the parties allowed to sue under § 1132(a), the state argued that any action that required an interpretation or application of ERISA "arose under" the laws of the United States and created § 1331 jurisdiction. [*991] Writing for a unanimous Court, Justice Brennan did not agree, and held that despite the statute's broad scope, the Congress did not intend for ERISA to preempt every cause of action relating to benefit plans. Thus, the Court concluded, "a suit by state tax authorities . . . does not 'arise under' ERISA . . . [because] the State's right to enforce its tax levies is not of central concern to the federal statute." 463 U.S. at 25-26.

Despite the Court's refusal to invoke federal question jurisdiction in Franchise Tax Board, its decision should not be read as a rejection of the application of § 1331 to other claims governed by ERISA, especially those that require application of federal common law. n8 The situation presented in Franchise Tax Board was unusual (as it involved the state [**17] taxing power and an entity not subject to

ERISA regulation), and so the Court was not faced with and did not decide whether federal question jurisdiction could be predicated on the basis of federal common law in accordance with City of Milwaukee. In contrast, Delta Air Lines represented a more typical ERISA action as there several companies subject to ERISA regulation brought declaratory judgment actions alleging that ERISA preempted several state benefit laws. Noting the difference from Franchise Tax Board, which the Court said "d[id] not call into question the lower courts' jurisdiction to decide these cases," the Court held that the plaintiffs "present[ed] a federal question over which the federal courts have jurisdiction under 28 U.S.C. § 1331 to resolve." 463 U.S. at 96 n. 14. See also Metropolitan Life Ins. Co. v. Taylor, 481 U.S. 58, 64-67, 95 L. Ed. 2d 55, 107 S. Ct. 1542 (1987) (claim of ERISA preemption that is also within scope of § 1132(a) arises under laws of United States for purposes of § 1331).

n8 In Northeast Department ILGWU v. Teamsters Local Union No. 229, 764 F.2d 147, 165-167 (3d Cir. 1985), all three panel members reached different conclusions regarding the effect of Franchise Tax Board and the jurisdictional basis of a claim brought by one employee benefit plan against another. Judges Becker and Sloviter agreed that § 1331 provided the basis for jurisdiction over a question implicating ERISA, but District Judge Fullam, sitting by designation, held that the express jurisdictional grant of § 1132(a)(1)(B) provided the appropriate basis. However, Judges Becker and Sloviter disagreed as to the reasons for § 1331 jurisdiction. Interpreting City of Milwaukee, Franchise Tax Board and Delta Air Lines, Judge

> Becker held, as we do here, that a claim requiring the application of federal common law arises under the laws of the United States. Disagreeing, Judge Sloviter argued that Franchise Tax Board "expressly rejected" the view that "arising under" jurisdiction may be created when federal common law supplies the rule of decision. 764 F.2d at 165-66 (Sloviter, J., concurring). Rather, Judge Sloviter found that § 1331 jurisdiction was proper because, like the plaintiffs in Delta Air Lines, the Northeast Department plaintiffs brought suit to clarify their obligations under an ERISA-governed plan. Id.

This disagreement was clarified partially by the Third Circuit in Airco. There, Judge Higginbotham "agree[d]" with Judge Becker's view that Franchise Tax Board did not foreclose § 1331 jurisdiction over claims that could arise under the federal common law of ERISA, so long as the claims were of "central concern" to ERISA. 850 F.2d at 1033-34 n. 5. We find that view of Franchise Tax Board persuasive and so adopt it today.

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We read Franchise Tax Board and Delta Air Lines to provide, "at a minimum," Airco, 850 F.2d at 1033 n. 5, for federal question jurisdiction under ERISA where the issue presented, whether it be the creation of federal common law or the interpretation of a specific ERISA provision, is of "central concern" to the statute. We believe the instant case meets this condition. As will be shown below, the issue of whether federal courts should impart unjust enrichment principles into the gaps left by ERISA is one that has divided

the courts. Similarly, the issue of whether employers and plan administrators should receive the benefit of these common law principles requires an examination of several collateral ERISA provisions as well as the concerns behind the formulation of the statute. Consequently, we conclude that "the absence of an express statutory grant of jurisdiction in § 1132 of ERISA is, under the rationale of [City of Milwaukee], irrelevant, and this claim may be adjudicated in federal court pursuant to 28 U.S.C. § 1331(a)." Northeast Department, 764 F.2d at 155.

[*992]III.

Having established that federal question jurisdiction exists and that the dispute is governed by the federal common law of ERISA, we must now consider whether such common law should include the unjust enrichment remedy sought by Provident. Like many issues that involve ERISA, the federal courts are divided over the creation of a federal common law of unjust enrichment. Compare Cummings By Techmeier v. Briggs & Stratton, 797 F.2d 383, 390 (7th Cir. 1986) (courts should only invoke federal common law of unjust enrichment in "limited circumstances"), and Van Orman v. American Ins. Co., 680 F.2d 301, 312 (3d Cir. 1982) (no federal common law cause of action under doctrine of unjust enrichment when "such a right would override a contractual provision"), and Amato v. Western Union Int'l, 773 F.2d 1402 (2d Cir. 1985) (no ERISA common law of unjust enrichment in "circumstances of this case"), with Airco Industrial Gases v. Teamsters Health & Welfare Pension Fund, 618 F. Supp. 943, 950 (D.Del. 1985) (included within grant of authority to create federal common law "is the power, in appropriate circumstances, to order

restitution to prevent unjust enrichment"), with Morales v. Pan American Life Ins. Co., 718 F. Supp. 1297, 1301 (E.D.La. 1989) ("creation of a federal common law of unjust enrichment . . . would be inconsistent with ERISA's terms and policies."). Cf. Whitworth, 794 F.2d at 235-36 (finding federal common law cause of action by employer to recover mistakenly paid pension contributions); Dime Coal Co. v. Combs, 796 F.2d 394, 397-99 (11th Cir. 1986) (reaching contrary conclusion to Whitworth).

A.

When entering the fray, we must keep in mind two points. The first involves general concerns about ERISA and federal common law. Despite the power of the federal courts to fill in the interstices of ERISA, we must respect the fact that Congress in creating ERISA has "established an extensive regulatory network and has expressly announced its intention to occupy the field." Van Orman, 680 F.2d at 312. Accordingly, we must proceed cautiously in creating additional rights under the rubric of federal common law, and remember that we do not possess carte blanche authority to "use state common law to re-write a federal statute." Nachwalter v. Christie, 805 F.2d 956, 960 (11th Cir. 1986).

It was such concerns that prompted Judge Butzner to announce recently that "we are constrained to fashion only those remedies that are appropriate [**21] and necessary to effectuate the purposes of ERISA." U.S. Steel Mining Co. v. District 17, United Mine Workers of America, 897 F.2d 149, 153 (4th Cir. 1990). In Steel Mining, an employer and a pension fund, relying on § 1132(a) of ERISA, sought to recover extracontractual restitution and attorney's fees from

a union. The employer and fund had paid these costs pursuant to a West Virginia statute that was subsequently declared to be preempted by ERISA. Declining to engraft a remedy for extracontractual restitution under the guise of federal common law, the court noted that "Congress did not intend that federal courts should develop common law to decide . . . issues that bear at best a most attenuated relation to the purposes of ERISA." 897 F.2d at 153.

In addition, we also recognize the concerns that have prompted several courts to decline to impose a federal common law of unjust enrichment. In Cummings By Techmeier v. Briggs & Stratton, 797 F.2d 383, 390 (7th Cir. 1986), the Seventh Circuit held that fashioning a federal common law unjust enrichment doctrine, although permissible in other circumstances, was inappropriate when it would override a contractual provision in [**22] a pension plan. Since the "enrichment" in Cummings By Techmeier was authorized by the express terms of the plan, the court concluded that it would not vindicate any "important statutory policy" to supplement the defined remedies in ERISA. 797 F.2d at 390-91. Similarly, in Van Orman v. American Ins. Company, 680 F.2d 301, 312 (3d Cir. 1982), the Third Circuit held that plan participants were not [*993] entitled, under the doctrine of unjust enrichment, to portions of an actuarial plan surplus. Writing for the court, Chief Judge Seitz stated that because the plan document did not afford the plaintiffs any right to the surplus, contravening the provision would "require[] a particularly strong affirmative indication that such a [common law] right would effectuate a statutory policy." 680 F.2d at 313. Finally, we note the decision in Morales v. Pan American Life Ins. Co., 718 F. Supp. 1297, 1301 (E.D.La. 1989), which held that

"quasi-contractual remedies [such as unjust enrichment] have no place where there is a contract between the parties." 718 F. Supp. at 1301.

B.

Recognizing these caveats, we nonetheless conclude that fashioning a federal common law rule of unjust enrichment is appropriate in the circumstances of this case. In developing this rule, we look to the plan contract itself, the statutory policies of ERISA, and state law. See Fox Valley & Vicinity Construction Workers Pension Fund v. Brown, 897 F.2d 275, 281 (7th Cir. 1990) (en banc). Unlike the plan documents in Cummings By Techmeier, which explicitly authorized the enrichment, and the one in Van Orman, which was silent as to the plan surplus, the plan contract in the present case provided for repayment of the advanced monies. Thus, the creation of a common law remedy here would further the contract between the parties and effectuate the clear intent of Provident's "Acts of Third Parties" clause. Second, the remedy is in accord with the statutory provision in ERISA that allows for the return of mistakenly paid contributions made by employers to multiemployer plan funds. See ERISA § 403(c)(2)(A), 29 U.S.C. § 1103(c)(2)(A). Recently, several courts have cited to § 1103(c)(2)(A) in creating a common law remedy for employers in their suits to recover erroneous payments to pension funds. See, e.g., Plucinski v. I.A.M. Nat'l Pension Fund, 875 F.2d 1052, 1058 (3d Cir. 1989) ("if we did not recognize this cause of action it could lead to severely inequitable results that we do not believe were intended by Congress"). Although the payment made by Provident was probably not mistakenly advanced, § 1103(c)(2)(A) indicates

a desire to ensure that plan funds are administered equitably and that no one party, not even plan beneficiaries, should unjustly profit. Cf. Carl Colteryahn Dairy, Inc. v. Western Pennsylvania Teamsters & Employers Pension Fund, 847 F.2d 113, 122 (3d Cir. 1988) (the rule that "a party should not be allowed to profit from its own wrongs" is "particularly apposite when dealing with [ERISA]" because Congress has emphasized the "equitable character" of these plans). As in the Plucinski case, reaching a contrary result would "discourage some employers from operating ERISA qualifying plans. It thus furthers the purposes of ERISA to recognize this cause of action." 875 F.2d at 1058.

Finally, the facts of the instant case fit the archetypal unjust enrichment scenario. As Provident repeatedly reminds us, the result in this case is an inequitable one; the record indicates that Waller received a double recovery despite knowing about the plan's [**25] reimbursement provision, and despite the absence of a requirement that Provident's payment be made in the first place. Consequently, Provident argues, it is entitled to recover under a quasi-contractual theory. In Virginia, the "law will imply a promise to pay for goods received," Kern v. Freed Co., 224 Va. 678, 680, 299 S.E.2d 363, 365 (1983), and several cases recognize the related theory of quantum meruit, which holds that when one party performs services at the request of the other party to a contract, "the law creates an obligation, which is an implied-at-law contract, to pay a reasonable compensation. . . ." Humphreys Railways v. F/V Nils S, 603 F. Supp. 95, 98 (E.D.Va. 1984). As summarized by a national commentator, three elements encompass the equitable remedy of unjust enrichment and quasi-contract: the plaintiff must show that (1) he had a reasonable expectation of payment, (2)

the defendant should reasonably have expected to pay, or (3) society's reasonable expectations of person and [*994] property would be defeated by nonpayment. C. Kaufman, Corbin on Contracts § 19A, at 50 (Supp. 1989).

In the instant case, all three elements are apparent. Provident reasonably [**26] expected to be reimbursed for its rather liberal advancements; Waller clearly was aware of the plan's "Acts of Third Parties" provision when she requested and then accepted the benefits; and the interests of society, as reflected by the goals of ERISA and efficient plan administration, would be served by allowance of an equitable remedy. Accordingly, we hold, in the circumstances of the case, that it is appropriate for a federal court to weave into the statutory fabric of ERISA the federal common law remedy of unjust enrichment. n9

> n9 Given this disposition, we leave undisturbed the district court's finding on class certification.

REVERSED.